BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation And Petition to Revoke Probation Against:	)	
Atsuko Eubank Rees, M.D.	)	**Case No. 800-2017-037857**
Physician's and Surgeon's Certificate No. C 41745	)	
Respondent	)	

DECISION

The attached Stipulated Surrender of License and Disciplinary Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on March 22, 2019 **.**

IT IS SO ORDERED March 15, 2019 **.**

MEDICAL BOARD OF CALIFORNIA

By: _____
Kimberly Kirchmeyer
Executive Director

XAVIER BECERRA
Attorney General of California
STEVE DIEHL
Supervising Deputy Attorney General
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Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation And Petition to Revoke Probation Against: **ATSUKO EUBANK REES, M.D.** **1890 Diablo Drive** **San Luis Obispo, CA 93405** **Physician's and Surgeon's Certificate No. C 41745** Respondent.	Case No. 800-2017-037857 **STIPULATED SURRENDER OF LICENSE AND DISCIPLINARY ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Medical Board of California (Board). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Michael C. Brummel, Deputy Attorney General.

2. Atsuko Eubank Rees, M.D. (Respondent) is represented in this proceeding by attorney Mark B. Connely, Esq., 1319 Marsh Street, 2nd Floor, San Luis Obispo, CA 93401.

3. On or about February 19, 1985, the Board issued Physician's and Surgeon's Certificate No. C 41745 to Atsuko Eubank Rees, M.D. (Respondent). The Physician's and Surgeon's Certificate was on probationary status at all times relevant to the charges brought in the First Amended Accusation and Petition to Revoke Probation No. 800-2017-037857 and expired on September 30, 2018.

JURISDICTION

4. The Accusation and Petition to Revoke Probation was filed before the Medical Board of California (Board). It was served along with all other statutorily required documents on Respondent on November 1, 2017. Respondent timely filed her Notice of Defense contesting the Accusation and Petition to Revoke Probation.

5. On or about May 1, 2018, the Board filed the First Amended Accusation and Petition to Revoke Probation No. 800-2017-037857. The First Amended Accusation and Accusation/Petition to Revoke Probation and all other statutorily required documents were properly served on Respondent on May 1, 2018. A copy of the First Amended Accusation and Accusation/Petition to Revoke Probation is attached as Exhibit A and incorporated by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in the First Amended Accusation and Petition to Revoke Probation No. 800-2017-037857. Respondent also has carefully read, fully discussed with counsel, and understands the effects of this Stipulated Surrender of License and Disciplinary Order.

7. Respondent is fully aware of her legal rights in this matter, including the right to a hearing on the charges and allegations in the First Amended Accusation and Petition to Revoke Probation No. 800-2017-037857; the right to confront and cross-examine the witnesses against her; the right to present evidence and to testify on her own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

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8. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

9. Respondent does not contest that, at an administrative hearing, complainant could establish a prima facie case with respect to the charges and allegations contained in the First Amended Accusation and Petition to Revoke Probation No. 800-2017-037857 and that she has thereby subjected her license to disciplinary action. Respondent agrees that if she ever petitions for reinstatement of her Physician's and Surgeon's Certificate No. C 41745, all of the charges and allegations contained in First Amended Accusation and Petition to Revoke Probation No. 800-2017-037857 shall be deemed true, correct and fully admitted by Respondent for purposes of that reinstatement proceeding or any other licensing proceeding involving respondent in the State of California.

10. Respondent agrees that cause exists for discipline and hereby surrenders her Physician's and Surgeon's Certificate No. C 41745 for the Board's formal acceptance.

11. Respondent understands that by signing this stipulation she enables the Board to issue an order accepting the surrender of her Physician's and Surgeon's Certificate No. C 41745 without further process.

CONTINGENCY

12. Business and Professions Code section 2224, subdivision (b), provides, in pertinent part, that the Medical Board "shall delegate to its executive director the authority to adopt a stipulation for surrender of a license."

13. This Stipulated Surrender of License and Disciplinary Order shall be subject to approval of the Executive Director on behalf of the Medical Board. The parties agree that this Stipulated Surrender of License and Disciplinary Order shall be submitted to the Executive Director for her consideration in the above-entitled matter and, further, that the Executive Director shall have a reasonable period of time in which to consider and act on this Stipulated Surrender of License and Disciplinary Order after receiving it. By signing this stipulation, Respondent fully understands and agrees that she may not withdraw her agreement or seek to

rescind this stipulation prior to the time the Executive Director, on behalf of the Medical Board, considers and acts upon it.

14. The parties agree that this Stipulated Surrender of License and Disciplinary Order shall be null and void and not binding upon the parties unless approved and adopted by the Executive Director on behalf of the Board, except for this paragraph, which shall remain in full force and effect. Respondent fully understands and agrees that in deciding whether or not to approve and adopt this Stipulated Surrender of License and Disciplinary Order, the Executive Director and/or the Board may receive oral and written communications from its staff and/or the Attorney General's Office. Communications pursuant to this paragraph shall not disqualify the Executive Director, the Board, any member thereof, and/or any other person from future participation in this or any other matter affecting or involving Respondent. In the event that the Executive Director on behalf of the Board does not, in her discretion, approve and adopt this Stipulated Surrender of License and Disciplinary Order, with the exception of this paragraph, it shall not become effective, shall be of no evidentiary value whatsoever, and shall not be relied upon or introduced in any disciplinary action by either party hereto. Respondent further agrees that should this Stipulated Surrender of License and Disciplinary Order be rejected for any reason by the Executive Director on behalf of the Board, Respondent will assert no claim that the Executive Director, the Board, or any member thereof, was prejudiced by its/his/her review, discussion and/or consideration of this Stipulated Surrender of License and Disciplinary Order or of any matter or matters related hereto.

15. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Surrender of License and Disciplinary Order, including Portable Document Format (PDF) and facsimile signatures thereto, shall have the same force and effect as the originals.

16. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Order:

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ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. C 41745, issued to Respondent Atsuko Eubank Rees, M.D., is surrendered and accepted by the Medical Board of California.

1. The surrender of Respondent's Physician's and Surgeon's Certificate and the acceptance of the surrendered license by the Board shall constitute the imposition of discipline against Respondent. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Medical Board of California.

2. Respondent shall lose all rights and privileges as a physician and surgeon in California as of the effective date of the Board's Decision and Order.

3. Respondent shall cause to be delivered to the Board her pocket license and, if one was issued, her wall certificate on or before the effective date of the Decision and Order.

4. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked or surrendered license in effect at the time the petition is filed, and all of the charges and allegations contained in First Amended Accusation and Petition to Revoke Probation No. 800-2017-037857 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

5. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in the First Amended Accusation and Petition to Revoke Probation No. 800-2017-037857 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

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ACCEPTANCE

I have carefully read the above Stipulated Surrender of License and Disciplinary Order and have fully discussed it with my attorney, Mark B. Connely, Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Surrender of License and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: Feb 9, 2019

Atsuko E Rees MD

ATSUKO EUBANK REES, M.D.
Respondent

I have read and fully discussed with Respondent Atsuko Eubank Rees, M.D. the terms and conditions and other matters contained in this Stipulated Surrender of License and Disciplinary Order. I approve its form and content.

DATED: Feb 27, 2019

MARK B. CONNELY, ESQ.
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Surrender of License and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California of the Department of Consumer Affairs.

Dated:

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
STEVE DIEHL
Supervising Deputy Attorney General

MICHAEL C. BRUMMEL
Deputy Attorney General
Attorneys for Complainant

ACCEPTANCE

I have carefully read the above Stipulated Surrender of License and Disciplinary Order and have fully discussed it with my attorney, Mark B. Connely, Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Surrender of License and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: _____

ATSUKO EUBANK REES, M.D.
Respondent

I have read and fully discussed with Respondent Atsuko Eubank Rees, M.D. the terms and conditions and other matters contained in this Stipulated Surrender of License and Disciplinary Order. I approve its form and content.

DATED: _____

MARK B. CONNELY, ESQ.
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Surrender of License and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California of the Department of Consumer Affairs.

Dated: 2/27/2019

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
STEVE DIEHL
Supervising Deputy Attorney General

MICHAEL C. BRUMMEL
Deputy Attorney General
Attorneys for Complainant

Exhibit A

First Amended Accusation and Petition to Revoke Probation No. 800-2017-037857

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Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation and Petition to Revoke Probation Against: **Atsuko Eubank Rees, M.D.** **1890 Diablo Drive** **San Luis Obispo, CA 93405** **Physician's and Surgeon's Certificate No. C41745,** Respondent.	Case No. 800-2017-037857 **FIRST AMENDED ACCUSATION AND PETITION TO REVOKE PROBATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this First Amended Accusation and Petition to Revoke Probation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about February 19, 1985, the Medical Board issued Physician's and Surgeon's Certificate No. C 41745 to Atsuko Eubank Rees, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on September 30, 2018, unless renewed.

3. In a disciplinary action entitled "In the Matter of the Accusation Against: Atsuko Eubank Rees, M.D.," Case No. 08-2009-203165, the Board issued a Decision, effective May 17, 2013 (May 17, 2013 Board Decision), in which Respondent's Physician's and Surgeon's Certificate was revoked. However, the revocation was stayed and Respondent was placed on probation for a period of five (5) years with certain terms and conditions. A copy of the May 17, 2013 Board Decision is attached hereto as Exhibit "A" and is incorporated by reference.

JURISDICTION

4. This First Amended Accusation and Petition to Revoke Probation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

5. Section 2227 of the Code states:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provision of this chapter:

"(1) Have his or her license revoked upon order of the board.

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board."

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

"(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

"(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education

activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1."

6. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate.

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the

proposed registration program described in Section 2052.5.

"(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board."

7. Section 2242 of the Code states:

"(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct.

"(b) No licensee shall be found to have committed unprofessional conduct within the meaning of this section if, at the time the drugs were prescribed, dispensed, or furnished, any of the following applies:

"(1) The licensee was a designated physician and surgeon or podiatrist serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and if the drugs were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return of his or her practitioner, but in any case no longer than 72 hours.

"(2) The licensee transmitted the order for the drugs to a registered nurse or to a licensed vocational nurse in an inpatient facility, and if both of the following conditions exist:

"(A) The practitioner had consulted with the registered nurse or licensed vocational nurse who had reviewed the patient's records.

"(B) The practitioner was designated as the practitioner to serve in the absence of the patient's physician and surgeon or podiatrist, as the case may be.

"(3) The licensee was a designated practitioner serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and was in possession of or had utilized the patient's records and ordered the renewal of a medically indicated prescription for an amount not exceeding the original prescription in strength or amount or for more than one refill.

"(4) The licensee was acting in accordance with Section 120582 of the Health and Safety Code."

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8. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

9. Respondent has subjected her Physician's and Surgeon's License No. C41745 to disciplinary action under section 2227, as defined by section 2234 (b), of the Code, in that she committed gross negligence in the care and treatment of Officer A[1], Officer B, Patient D, Patient E, Patient F, and Patient G, as more particularly alleged hereafter.

Officer A

10. On or about August 21, 2015, Officer A, an undercover police officer, presented to Respondent's office as a 36-year-old male complaining of overall body soreness from running and lifting weights lasting approximately two weeks. Officer A explained that ibuprofen and muscle relaxers were not effective, and he wanted something stronger. Officer A told Respondent that he had taken Vicodin[2] and Percocet[3]. Respondent documented that she conducted a physical examination on Officer A; however, she did not perform a physical examination at this visit. Respondent told him that she could not give him very many pills because he didn't have degenerative disc disease and didn't need a hip replacement or "anything like that." Respondent said that she would give him a prescription for 30 pills and recommended that he try marijuana. Respondent told Officer A that he should not be using this medication at his age. Respondent told Officer A that opiates are strong, prescribing them is "frowned upon," that she didn't think "most doctors would give this to you," and that she was feeling very hesitant

[1] Identifiers are used in place of patient names to protect the patients' privacy.

[2] Vicodin is a brand name for acetaminophen and hydrocodone bitartrate, a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022. Vicodin is an opiate/narcotic medication.

[3] Percocet is a brand name for oxycodone and acetaminophen, a Schedule II controlled substances pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

to prescribe to him. Officer A told Respondent that only the 10 mg Norco[4] pills have worked for him in the past. Respondent then stated that she was going to prescribe him the 5mg Norcos "if there is such a thing." Respondent considered prescribing Norco 5/325 #30, but ultimately prescribed the higher dosage of Norco 10/325 #20 without documenting any rationale for the increase in the dosage and agreed that he could return to her office in 30 days. Respondent did not perform any physical examination on Officer A. Officer A's entire visit lasted approximately seven minutes.

11. On or about September 23, 2015, Officer A returned to Respondent's office for a follow up visit seeking a refill of his Norco. Officer A told Respondent that he was feeling great and asked for 60 pills of Norco. Respondent told him that someone of his age shouldn't need the Norco. She told him that if was going to need more than one Norco a day he would need to go to a pain management doctor. Respondent admitted that Officer A had no evidence of a painful condition and stated that he should not need opioids at his age. Respondent did not perform a physical examination. Despite the request, Respondent prescribed Officer A 30 pills of Norco 10/325.

12. Respondent did not perform a physical examination during the first visit. Respondent failed to document an adequate history of the presenting illness. Respondent did not document the duration, location, onset, severity, or context of Officer A's reported body pain. Respondent did not ask Officer A if there were any aggravating or alleviating factors to his pain. Respondent did not adequately document the use and efficacy of over the counter medications in the treatment of Officer A's symptoms prior to prescribing controlled substances. Respondent failed to recommend and/or document activity modification, ice or heat application or discontinuation of the current exercise program until the pain subsided. Officer A presented to Respondent requesting something stronger than muscle relaxers, and specifically mentioned Norco and Percocet. Respondent stated that she was going to prescribe a lower dose of controlled

[4] Norco is a brand name for acetaminophen and hydrocodone bitartrate, a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022. Norco is an opiate/narcotic medication.

substances during the visit, and then increased the dose of controlled substances without any explanation or justification. Respondent ignored the red flags and drug seeking behavior, and elected to prescribe controlled substances to Officer A at the initial visit as a first line of therapy. Respondent's physical examination of Officer A and documentation of the visit were insufficient to justify a prescription of controlled substances.

13. Respondent did not perform a physical examination of Officer A during his return visit for refills of his controlled substances. Respondent did not perform an adequate evaluation of Officer A's complaint of body soreness. Respondent prescribed controlled substances to Officer A for a second time, even though he stated that he was feeling great and specifically requested that Respondent increase the quantity of controlled substances. Respondent ignored the red flags and drug seeking behavior and continued to prescribe controlled substances to Officer A. Respondent prescribed controlled substances to Officer A despite the absence of any evidence of a painful condition or clinical indication to justify the prescription of controlled substances.

14. Respondent committed gross negligence in her care and treatment of Officer A, which included, but was not limited to the following:

A. Paragraphs 10 to 13, are hereby incorporated by reference as if fully set forth herein;

B. Respondent's prescription of controlled substances to Officer A constitutes an extreme departure from the standard of care.

Officer B

15. On or about May 7, 2015, Officer B, an undercover police officer, presented to Respondent's office as a 60-year-old male with elevated blood pressure and history of depression and anxiety seeking to establish primary care. Officer B paid $130 in cash for his visit at the front desk prior to meeting Respondent. The medical assistant documented that Officer B's blood pressure was 160/105. Officer B told Respondent that he was going through a nasty divorce and was experiencing stress, depression and insomnia. Respondent wrote that he was "going through a divorce, L shoulder pain from time to time, pt is a plumber." He explained that the Vicodin seemed to help him because "it gives me that floating sensation." Officer B admitted that he had

taken Ambien[5] and Norco that he had obtained from friends and specifically asked Respondent for prescriptions for Norco or Vicodin. Respondent replied, "Well I can't give you Vicodin or Norco for sleep. It has to be for pain." Officer B then told Respondent, for the first time, that his shoulder did bother him on occasion. Respondent asked Officer B how much Norco he was taking previously. Respondent told him that while taking Norco he needed to come into the office every month to renew his prescription. Officer B then asked Respondent if he could have the highest strength Norco available. Respondent briefly checked Officer B's heart, then prescribed him 30 pills of Norco and directed him to return in one month. The entire patient encounter with Respondent lasted approximately four minutes.

16. On or about August 21, 2015, Officer B returned to Respondent for a refill of his Norco. Officer B paid $100 in cash for his visit. The medical assistant recorded his blood pressure as 140/90. Respondent asked Officer B if he was here for a refill on his medications and if he was still working as a plumber. Officer B told Respondent that he was still going through his divorce and suffering from depression and insomnia. Respondent briefly listened to Officer B's heart and then provided him with a refill prescription for 30 pills of Norco. Officer B's entire visit lasted approximately four minutes.

17. Respondent did not perform a physical examination of Officer B on his initial visit. Respondent failed to document an adequate and accurate patient history. Respondent did not ask Officer B any additional questions to evaluate his depression and insomnia. Respondent did not ask Officer B any questions about his mood symptoms or if he had thoughts of suicide. Respondent did not ask Officer B any questions about his history of substance abuse. Respondent did not document the duration, location, onset, severity, or context of Officer B's reported shoulder pain. Respondent did not ask Officer B if there were any aggravating or alleviating factors to his pain. Respondent did not adequately document the use and efficacy of over the counter medications in the treatment of Officer B's symptoms prior to prescribing opiate

[5] Ambien is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. It is a sedative used to treat insomnia.

medication. Respondent failed to recommend activity modification, ice or heat application. Officer B presented to Respondent with depression and insomnia, seeking controlled substances to cope with his stressful situation and admitted that he had taken medications from friends without a valid prescription in the past. Respondent ignored the red flags and drug seeking behavior and prescribed controlled substances as a first line therapy to Officer B. Respondent failed to conduct an adequate patient examination to justify the prescription of opioid medications.

18. At the follow up visit, Officer B returned seeking refills and still complaining of depression and insomnia. Respondent failed to conduct a physical examination and did not ask any additional questions to elicit information about Officer B's shoulder pain. Respondent failed to document any information in Officer B's medical record about his shoulder pain during his return visit. Respondent diagnosed Officer B with "chronic pain" absent evidence to support the diagnosis. Respondent ignored the red flags and drug seeking behavior and refilled Officer B's prescription for controlled substances without a physical exam or clinical justification for the prescription.

19. Respondent committed gross negligence in her care and treatment of Officer B, which included, but was not limited to the following:

A. Paragraphs 15 to 18, are hereby incorporated by reference as if fully set forth herein;

B. Respondent failed to adequately evaluate Officer B's complaint of shoulder pain, which constitutes an extreme departure from the standard of care;

C. Respondent's prescription of controlled substances to Officer B constitutes an extreme departure from the standard of care.

Patient D

20. On or about February 19, 2013, Patient D, a 21-year-old student presented to Respondent for the first time requesting Suboxone[6] treatment. Patient D told Respondent that he

[6] Suboxone is a combination of buprenorphine and naloxone used to treat opiate addiction. It is a Schedule III controlled substance pursuant to Health and Safety Code section 11056,

had tried Suboxone previously with no side effects. Respondent identified a medical history that included back pain, physical therapy, prior prescriptions for Norco and Soma.[7] Patient D admitted to intravenous illicit drug use, illegal use of prescription opiates, heroin and reported that he was taking 7-8 pills of OxyContin[8] 30 mg each day. Respondent did not document any complaints about sleep or insomnia. Respondent failed to elicit any additional information regarding the prior Suboxone treatment including whether it was used in the induction phase or as a part of other substance abuse treatments. Respondent failed to identify any of Patient D's prior treating physicians. Respondent's physical examination concluded that the general and neuro examination were normal. The assessment for Patient D identified insomnia, and opioid dependence. Respondent's plan was for Patient D to get counseling and return to the clinic in one month. Respondent provided Patient D a patient contract for controlled substances, which he completed. Patient D also completed a Suboxone questionnaire and reported that he was experiencing symptoms of withdrawal, had trouble with anxiety or sleeping, and had experienced cravings and/or urges to use drugs or alcohol. Respondent did not elicit any additional information from Respondent relating to his answers on the Suboxone questionnaire. Respondent prescribed Patient D Suboxone 8/2 film #30 and Temazepam[9] 15 mg #30.

21. On or about March 26, 2013, Patient D presented to Respondent's physician assistant seeking a refill of his Suboxone medications. Patient D completed a Suboxone questionnaire that indicated he had been using Suboxone since his prior visit. Respondent's physician assistant documented that Patient D's father was a psychologist and was with him at the appointment. Patient D explained that he has had trouble sleeping since age 11 and had previously used

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subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022.

[7] Soma, a brand name for carisoprodol, is a muscle relaxant with a known potentiating effect on narcotics. It is a muscle relaxer that works by blocking pain sensations between the nerves and the brain. In December 2011, the Federal Drug Administration listed carisoprodol as a Schedule IV controlled substance (76 Fed.Reg. 77330 (Dec. 12, 2011).) Soma is also a dangerous drug pursuant to Business and Professions Code section 4022.

[8] Oxycodone (OxyCONTIN, Roxicodone) is a Schedule II controlled substance pursuant to Health and Safety code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

[9] Temazepam is a generic brand for Restoril and is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022

marijuana for medical purposes "which helped," but he has since stopped using marijuana. The medical records for Patient D fail to contain any information about his current sleeping problems. Patient D's father reported that his son suffers from anxiety. Respondent's physician assistant noted that she told Patient D to stop taking temazepam after Patient D admitted he had taken some without a prescription that he obtained from a friend. Respondent's physician assistant diagnosed Patient D with opioid dependence, anxiety and insomnia. Respondent's physician assistant prescribed Suboxone 8/2 mg film ½ a film twice daily #30 and Xanax[10] 2 mg daily #30.

22. On or about April 5, 2013, Patient D called Respondent's office and reported that he had been taking more of the Suboxone than what he was prescribed and ran out early.

23. On or about April 19, 2013, Patient D returned to Respondent for refills on his medications. Patient D reported that he was doing well and taking 1 ¼ strips of Suboxone daily. He completed a Suboxone questionnaire admitting that he had been using oxycodone, experiencing withdrawal and planned to see a counselor the following week. Respondent failed to include any documentation relating to Patient D's report that he was continuing to take more Suboxone than he was prescribed. Respondent prescribed Patient D alprazolam, clonazepam[11] #45 and increased his Suboxone prescription from #30 to #38.

24. On or about August 8, 2013, Patient D returned to see Respondent accompanied by his father. Respondent's patient history stated that Patient D had previously started narcotics for a back injury from tennis that resulted in chronic pain and that he was doing well in school. Patient D reported that he had used drugs and that he was taking two clonazepam and one alprazolam each day. The assessments included anxiety, insomnia, and opioid dependence. Respondent's plan was for him to return to the clinic in one month. Respondent prescribed him Suboxone #30 and clonazepam #90. Respondent failed to document any explanation for the increase in the prescribed benzodiazepines.

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[10] Xanax, also known by the generic name of alprazolam, is a Schedule IV controlled substance pursuant to health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

[11] Clonazepam is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. It is an anti-anxiety medication in the benzodiazepine family.

25. On or about August 13, 2013, Patient D telephoned Respondent's office and admitted that he had been taking more clonazepam than what he had been prescribed. The medical records include a note next to the telephone message that states "must stick to med as prescribed."

26. On or about August 13, 2013, Patient D telephoned Respondent's office again complaining that he had been told that he could increase his clonazepam, but was denied when he called in. The medical record states that the patient is upset and would be coming in on August 19, 2013 for a visit.

27. On or about September 6, 2013, Patient D returned to Respondent with his father requesting medication refills and a sleep aid. Respondent noted that the patient was doing well with Suboxone, experiencing sleep issues and seeing two counselors. The assessments included insomnia and opioid dependence. Respondent's plan was to add Ambien; if that was unsuccessful, to prescribe Xanax in combination with clonazepam, and Patient D was instructed to return to the clinic in one month. Respondent wrote the works "IC given" and "warned" on the progress note without further explanation. Patient D participated in a urine drug screen, which was only positive for benzodiazepines. Respondent prescribed Patient D Suboxone #30, clonazepam #90 and Ambien.

28. On or about October 2, 2013, Patient D returned to Respondent for medication refills. Patient D admitted to using alcohol from September 14 through 16, 2013. Respondent failed to elicit any additional information about his alcohol use in violation of the controlled substances contract. Respondent noted that he still had some sleep problems and had decided on his own to increase his clonazepam in combination with Ambien. Respondent's assessment included opioid dependence and severe insomnia. The plan for Patient D was to return to the clinic in one month. Respondent prescribed Ambien, clonazepam, alprazolam and Suboxone.

29. On or about April 11, 2014, Patient D presented to Respondent for a follow up visit related to his Suboxone treatment. Respondent's medical records for the patient history state that he was having difficulty focusing in school and would like to try Adderall.[12] Respondent failed to

[12] Adderall XR (amphetamine and dextroamphetamine) are central nervous system stimulants that affect chemicals in the brain and nerves that contribute to hyperactivity and

elicit any information about his prior history of attention deficit disorder or use of amphetamines. Respondent failed to include an assessment or plan. Respondent prescribed Patient D Suboxone, Adderall, Ambien and alprazolam.

30. On or about May 9, 2014, Patient D completed a Suboxone questionnaire for Respondent. Patient D admitted that he was continuing to use alcohol.

31. On or about May 28, 2014, Patient D returned to Respondent complaining of a back injury that he suffered two weeks prior. Patient D had previously been treated in urgent care and was referred to physical therapy. Respondent failed to document if he was participating in physical therapy or if he had previously utilized physical therapy treatment. Respondent noted that she would decrease his medications and Adderall after Patient D finished his finals at school in two weeks. The assessments included back pain, insomnia, anxiety and attention deficit disorder. Respondent prescribed Patient D Suboxone, Soma #40, Ambien, alprazolam, and Adderall.

32. On or about August 21, 2014, Patient D returned to Respondent for medication refills. Respondent noted that the patient was only taking a single class this quarter and documented a normal back examination. Respondent prescribed Patient D Ambien, alprazolam, Adderall, and Suboxone.

33. On or about September 15, 2014, Respondent received a letter from Patient D's father expressing concern about a recent drug overdose. Patient D's father explained that his son had overdosed on Soma requiring emergency treatment and that this was the third time this had occurred. The patient's father believed that his son was trading his Adderall for Soma. Patient D had admitted to his father that he had continued to use heroin from February 2012 through February of 2014. Patient D was reportedly unwilling to participate in 12-step recovery groups and his performance in school was declining. Patient D's father urged Respondent not to prescribe any more Adderall or Soma and not to take his son's self-reporting at face value.

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impulse control. Adderall XR is a Schedule II controlled substance pursuant to Health and Safety code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

34. On or about September 19, 2014, Patient D returned to the clinic for medication refills. Respondent failed to document any additional information about the visit to the clinic. Respondent prescribed Patient D temazepam, alprazolam, Adderall, and Suboxone.

35. On or about October 6, 2014, Patient D returned to Respondent for medication refills accompanied by his father. Respondent documented that the patient's insomnia was worse and that he wanted to start using Ambien again. The assessments included insomnia, attention deficit disorder, and opioid dependence. Respondent prescribed Patient D Ambien, alprazolam, Adderall, and Suboxone. Respondent noted that she refilled his alprazolam prescription early because the patient had increased the amount on his own since the prior visit.

36. On or about October 7, 2014, Patient D's father wrote a second letter to Respondent expressing concern about his son. He explained that his son had takin an excessive amount of Soma again. This time, Patient D had become violent necessitating a visit by the police department. His father reported that Patient D had demanded all of his medications. Patient D's father stated that his son had been using alcohol and that he believed he was trading his Suboxone for Soma.

37. On or about October 17, 2014, Patient D telephoned Respondent's office stating that he was enrolled in school and wanted to increase his prescription for Adderall.

38. On or about October 22, 2014, Patient D returned to Respondent for refills of his medications, questions about Adderall, and was complaining of back pain. Patient D had an appointment scheduled with a spine surgeon in two weeks and reported that physical therapy was not successful in treating his back pain. Respondent noted that Patient D had overdosed on Soma, but his father had been providing him with only two pills a day since the overdose. The assessments included insomnia, anxiety, and lumbar/sacral spine. The plan was for Patient D to get an MRI related to his back pain. Respondent prescribed Patient D Soma #40.

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39. Respondent continued to prescribe Patient D buprenorphine,[13] Adderall, Ambien and alprazolam regularly through 2016. Patient D only performed a single urine drug screen during that time period which was negative for buprenorphine.

40. From on or about April 11, 2014 through July 18, 2016, Respondent and/or other health professionals at her clinic prescribed Patient D approximately 35 prescriptions for Adderall for a total of approximately 1,710 pills.

41. From on or about April 19, 2013 through July 18, 2016, Respondent and/or other health professionals at her clinic prescribed Patient D approximately 44 prescriptions for alprazolam for a total of approximately 1,530 pills.

42. From on or about September 6, 2013 through July 18, 2016, Respondent and/or other health professionals at her clinic prescribed Patient D approximately 39 prescriptions for Ambien for a total of approximately 1,180 pills.

43. From on or about January 29, 2015 through June 20, 2016, Respondent and/or other health professionals at her clinic prescribed Patient D approximately 21 prescriptions for buprenorphine for a total of approximately 590 doses.

44. From on or about April 19, 2013 through October 2, 2013, Respondent and/or other health professionals at her clinic prescribed Patient D approximately 7 prescriptions for clonazepam for a total of approximately 455 pills.

45. From on or about May 28, 2014 through December 22, 2014, Respondent and/or other health professionals at her clinic prescribed Patient D approximately 3 prescriptions for Soma for a total of approximately 120 pills.

46. From on or about February 19, 2013 through December 10, 2014, Respondent and/or other health professionals at her clinic prescribed Patient D approximately 25 prescriptions for Suboxone for a total of approximately 706 pills.

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[13] Buprenorphine is a generic form of Subutex, a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022. Buprenorphine is used to treat opioid addiction.

47. Respondent failed to properly evaluate Patient D related to his request to initiate drug therapy with Suboxone. Respondent failed to document any information about Patient D's self-reported history of taking Suboxone. Respondent failed to identify the prior prescriber of Suboxone or elicit information from the patient about his past circumstances requiring treatment with Suboxone.

48. Respondent failed to adequately manage Patient D's treatment with Suboxone. Respondent failed to discontinue Suboxone treatment after learning that Patient D was taking oxycodone in between visits to Respondent. Respondent failed to discontinue or alter Patient D's Suboxone treatment after repeated red flags of misuse including the patient changing the amount of medication that he was taking, suffering from withdrawal, drinking alcohol and taking opiates and benzodiazepines that were not prescribed to him. Respondent failed to make necessary changes to Patient D's treatment plan after Patient D committed multiple violations of the controlled substances contract. Respondent failed to refer Patient D to an addiction specialist. Respondent inappropriately continued to prescribe to Patient D after he admitted that he had self-titrated his Suboxone and benzodiazepines.

49. Respondent inappropriately prescribed multiple benzodiazepines to Patient D without first attempting to treat the patient with less dangerous options. Respondent failed to refer Patient D to psychiatry or to a sleep specialist for his self reported anxiety and insomnia. Respondent failed to make necessary changes to Patient D's treatment plan after learning that the patient was continuing to drink alcohol while being prescribed benzodiazepines and opiates.

50. Respondent inappropriately prescribed buprenorphine to Patient D in combination with multiple benzodiazepines for his self reported insomnia and anxiety. Respondent failed to modify her prescribing habits after she learned that the patient continued to drink alcohol. Respondent failed to document the extent of the patient's continued use of alcohol. Respondent failed to independently verify that Patient D was actually participating in mental health care.

51. Respondent failed to modify her prescribing practices after learning that the patient had suffered multiple overdoses, was diverting medication, and was trading Adderall and Suboxone for Soma. Respondent failed to adequately monitor Patient D, require urine drug

screenings or alter the amount of medication prescribed despite numerous warnings of diversion, misuse, and overdose.

52. Respondent diagnosed Patient D with insomnia without any documented efforts to obtain a history or cause of the patient's sleep problems. Respondent failed to treat Patient D with any low risk sleep aids or consult a sleep specialist prior to prescribing addictive combinations of benzodiazepines. Respondent inappropriately prescribed temazepam as a first line treatment for self-reported insomnia. Respondent inappropriately prescribed multiple concurrent benzodiazepines to Patient D for insomnia to be taken at the same time as Suboxone creating a serious risk for death by overdose.

53. Respondent failed to de-escalate Patient D's prescription drug use for insomnia after he reported that he was doing well. Respondent failed to document a comprehensive sleep history for Patient D. Respondent failed to refer Patient D to a sleep specialist after he continued to report problems sleeping.

54. Respondent failed to document a full history for Patient D's self-reported attention deficit disorder. Respondent failed to perform any diagnostic testing for attention deficit disorder after Patient D reported a history of problems focusing. Respondent failed to refer Patient D to a specialist for evaluation of his self-reported attention deficit disorder. Respondent failed to consider that the patient's problems focusing were related to her multiple prescriptions for opiates and benzodiazepines. Respondent failed to attempt to taper Patient D's prescriptions of opiates and benzodiazepines before initiating drug therapy with amphetamines for undiagnosed attention deficit disorder. Respondent failed to modify her treatment plan or confront the patient after learning from the patient's father that Patient D was diverting the Adderall in order to illegally obtain Soma. Respondent failed to adequately justify the need to continue prescribing Adderall to Patient D after learning that the patient was diverting the medication.

55. Respondent committed gross negligence in her care and treatment of Patient D, which included, but was not limited to the following:

A. Paragraphs 20 to 54, are hereby incorporated by reference as if fully set forth herein;

B. Respondent inappropriately prescribed controlled substances to Patient D;

C. Respondent lacked knowledge of the appropriate treatment with buprenorphine;

D. Respondent failed to adequately evaluate and treat Patient D's complaint of insomnia; and

E. Respondent failed to adequately evaluate and treat Patient D's complaint of attention deficit disorder.

Patient E

56. On or about January 20, 2012, Patient E presented to Respondent's physician assistant for the first time as a 23-year-old student complaining of fibromyalgia and lumbar/sacral back pain. Patient E reported that she was recently given Dilaudid[14] at the emergency department and that she had a high tolerance for pain. Respondent's physician assistant listed under the assessment that Patient E had fibromyalgia, chronic pain and muscle spasms. Respondent prescribed Patient E Soma 350 mg #60 to be taken twice daily, Percocet 10/325 #60 to be taken twice daily and instructed her to return in one month.

57. On or about February 20, 2012, Patient E presented to Respondent for the first time seeking a refill of her medications. Patient E reported that her pain level was a 5 or 6/10 on a normal day. She told Respondent that she had a recent flare up that resulted in a black out. Respondent's review of systems was positive for back pain, muscle soreness, joint pain/swelling, headaches, depression, anxiety, and memory loss. Respondent circled range of motion for the neck back and extremities on the physical exam. The assessments included fibromyalgia, muscle spasm, insomnia, and dysthymia. Respondent's only plan was to return to the clinic in one month. Respondent prescribed Patient E Soma #90 and Percocet #60.

58. On or about March 15, 2012, Patient E returned to Respondent for treatment and requested a refill on her anxiety prescriptions. Patient E reported that either a psychologist or a

[14] Dilaudid is a brand name for hydromorphone, an opioid pain medication commonly called a narcotic that is used to treat moderate to severe pain. Dilaudid can slow or stop your breathing and should not be used in larger amounts or longer periods than prescribed. Dilaudid may be habit-forming and can cause addiction, overdose or death if misused. Dilaudid is a Schedule II controlled substance under Health and Safety Code section 11055, and a Schedule II controlled substance under section 1308.12 of Title 21 of the Code of Federal Regulations and a dangerous drug as defined in Business and Professions Code section 4022.

psychiatrist had prescribed her alprazolam; however, there is no mention in the records of the patient previously taking diazepam. Respondent failed to obtain any records from either psychologist or the psychiatrist. The assessments included fibromyalgia, muscle spasms, insomnia generalized anxiety disorder, panic disorder, and seasonal allergies. Respondent's only plan was to return to the clinic in one month. Respondent prescribed diazepam[15] #30, alprazolam #30, Soma #90, and Percocet #60.

59. On or about April 23, 2012, Patient E returned to Respondent for refills on her medications and complaining that Tylenol was upsetting her stomach. Respondent prescribed diazepam #30, alprazolam #30, Soma #90 and Oxycodone #60.

60. On or about September 7, 2012, Patient E reported to MedStop Urgent Care requesting medication refills for Dilaudid, Norco, Soma, Doxycycline, spironolactone, alprazolam, and diazepam. Patient E left the clinic while the physician on duty was reviewing her CURES profile. The physician learned from reviewing Patient E's CURES profile that she was not being honest about the medications that she was taking. The physician documented his concern that it was likely that Patient E was misusing controlled substances and faxed his conclusions to Respondent's practice to be included as a part of Patient E's medical record.

61. On or about September 14, 2012, Patient E returned to Respondent for a follow up visit regarding her medications. Respondent documented that the patient was working full time and doing additional work cleaning. The physical examination was positive for tenderness in the lumbosacral area of her lower back. The assessments included fibromyalgia, anxiety, insomnia and back pain. Respondent's plan was partly illegible and directed the patient to return to the clinic in one month. Respondent prescribed Patient E Valium #30, alprazolam #20, oxycodone #60 and Soma #90.

62. On or about October 10, 2012, Patient E complained to Respondent that her oxycodone was causing itching. Respondent prescribed her Dilaudid #120 and Soma #90.

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[15] Diazepam (Valium) is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. Diazepam is in the class of benzodiazepines.

63. On or about November 8, 2012, Respondent prescribed Patient E Dilaudid #120 and Soma #90.

64. On or about December 6, 2012, Respondent prescribed Patient E Valium, Xanax, Dilaudid and Soma.

65. On or about December 26, 2012, Patient E notified the Respondent's clinic that her cat had knocked her entire bottle of hydromorphone 4 mg pills into the fish tank and she needed an early refill. Respondent refused to provide an early refill of her medications.

66. On or about January 3, 2013, Patient E visited Respondent for refills of her medications. Respondent failed to discuss and/or document any discussion relating to the request for early refills that was denied on December 26, 2012. Respondent refilled Patient E's prescriptions for Dilaudid, Soma, Valium, and Xanax. On the same day, the patient also obtained prescriptions for clonazepam #30 from her psychiatrist.

67. On or about January 29, 2013, Patient E visited Respondent's physician assistant reporting that she was able to be productive while on her current medications. Respondent's physician assistant noted that the physical examination was positive for tenderness in the back area. The assessments identified by Respondent's physician assistant included anxiety, arthralgia, chronic back pain, dysthymia, and insomnia. Respondent's physician assistant provided Patient E medications despite the recent denial of a request for an early refill and the patient seeking medications from both Respondent and her treating psychiatrist on the same day at the time of the last visit. Respondent's physician assistant prescribed hydromorphone 4 mg one pill four times daily #120, Soma 350 mg three times daily #90, diazepam 10 mg at bedtime #30, and alprazolam 2 mg every 6 hours as needed #20. The pharmacy refused to fill the prescriptions written by Respondent's physician assistant. The pharmacy contacted Respondent's physician assistant in writing stating that Patient E had already filled alprazolam and clonazepam prescriptions on January 3 and 31, 2012 that were written by another physician. Respondent's physician assistant wrote on the fax that she was unaware of Patient E's prescriptions from the other physician.

68. On or about February 21, 2013, Patient E returned to Respondent for medication refills. Respondent failed to discuss and/or document any discussion relating to the numerous

recent violations of the controlled substances contract. Respondent failed to order a urine drug screening for Patient E. Respondent prescribed Patient E Dilaudid, Soma, Valium, and alprazolam.

69. On or about April 23, 2013, the San Luis Obispo County Jail submitted a request for Patient E's medical records to Respondents office.

70. On or about May of 2013, Express Scripts sent a letter to Respondent's office about the duplication of prescriptions to Patient E for Xanax and Valium. Respondent failed to make any changes in her prescribing to Patient E despite the alert from Express Scripts.

71. On or about April 8, 2014, Patient E received a prescription for Norco from another physician.

72. On or about April 11, 2014, Patient E received another prescription for Norco from a new and separate physician.

73. On or about October 30, 2014, Patient E returned to Respondent for refills on her medications. Respondent failed to review the CURES database, which would have revealed the two Norco prescriptions from other providers on April 8 and 11, 2014. Patient E provided a urine drug screen, which was positive for amphetamine, methamphetamine, opiates, and oxycodone. Respondent prescribed Patient E Subutex, Soma #60, Valium, Xanax, and ibuprofen.

74. On or about January 26, 2015, Patient E returned to Respondent for a follow up on her medications. Patient E presented with a blood pressure of 150/88 and a rash. The patient reported attending a center to discontinue buprenorphine. Respondent prescribed Soma, Valium, Xanax, gabapentin[16], and doxycycline.

75. From on or about October 10, 2012 through October 1, 2014, Respondent and/or physicians working at her clinic prescribed Patient E approximately 28 prescriptions for hydromorphone for a total of approximately 3,505 pills.

76. From on or about February 20, 2012 through January 26, 2015, Respondent and/or physicians working at her clinic prescribed Patient E approximately 40 prescriptions for Soma for

[16] Gabapentin (Neurontin) is an anti-epileptic medication also called an anticonvulsant. It affects chemicals and nerves in the body that are involved in the cause of seizures and some types of pain. Gabapentin is a dangerous drug as defined in Section 4022.

a total of approximately 3,340 pills.

77. From on or about March 15, 2012 through January 26, 2015, Respondent and/or physicians working at her clinic prescribed Patient E approximately 36 prescriptions for diazepam for a total of approximately 1,120 pills.

78. From on or about October 23, 2013 through January 26, 2015, Respondent and/or physicians working at her clinic prescribed Patient E approximately 8 prescriptions for gabapentin for a total of approximately 930 pills.

79. From on or about March 15, 2012 through January 26, 2015, Respondent and/or physicians working at her clinic prescribed Patient E approximately 36 prescriptions for alprazolam for a total of approximately 570 pills.

80. From on or about April 23, 2012 through September 14, 2012, Respondent and/or physicians working at her clinic prescribed Patient E approximately 6 prescriptions for oxycodone for a total of approximately 360 pills.

81. From on or about February 20, 2012 through March 15, 2012, Respondent and/or physicians working at her clinic prescribed Patient E approximately 2 prescriptions for Percocet for a total of approximately 120 pills.

82. From on or about October 30, 2014 through December 3, 2014, Respondent and/or physicians working at her clinic prescribed Patient E approximately 2 prescriptions for buprenorphine for a total of approximately 60 pills.

83. Respondent failed to obtain outside medical records from prior treating physicians to verify the medications were appropriately indicated for Patient E. Respondent failed to discuss her treatment plans for Patient E with the patient's mental health care providers. Respondent failed to independently verify the patient's treatment and prescribing by her psychiatrist.

84. Respondent failed to document an adequate justification for the prescribing of multiple concurrent benzodiazepines. Respondent prescribed opiates in combination with multiple concurrent benzodiazepines and Soma to Patient E, which dramatically increased the risk of overdose or death for the patient. Respondent continued to prescribe multiple controlled substances to the patient despite reports that the patient was doing well and notes in the medical

record that Respondent believed the patient should decrease her medications. Respondent ignored multiple warning signs that Patient E was at risk for misusing or diverting controlled substances. Respondent made no significant change in the treatment plan for Patient E even after the patient sought early refills, attempted to obtain illegitimate prescriptions from another provider and even after being told that the patient's cat destroyed her controlled substances by knocking them in the fish tank. Despite the numerous warning signs of addiction and/or diversion, Respondent's response was to continue to prescribe Patient E Dilaudid.

85. Respondent was aware that Patient E presented numerous warning signs of addiction and/or diversion of controlled substances. Respondent failed to modify her treatment plan despite Patient E's violations of the controlled substances contract. Respondent failed to utilize the CURES database for evidence of misuse of controlled substances.

86. Respondent failed to adequately modify the patient's treatment plan despite multiple red flags for misuse and/or diversion of controlled substances. Respondent failed to cease prescribing and/or refer Patient E to an addiction specialist after the patient presented to the clinic with an altered level of consciousness, admitted to injecting heroin and provided a urine drug screen that was positive for methamphetamine. Respondent inappropriately discharged Patient E from her clinic with new prescriptions for an opiate, a barbiturate, an anti-inflammatory, and multiple benzodiazepines. Respondent inappropriately prescribed Patient E opiates to help the patient avoid withdrawal.

87. Respondent failed to document an adequate patient history related to the patient's report of a black out. Respondent failed to document an adequate patient history related to the patient's self-reported increased symptoms of fibromyalgia. Respondent failed to adequately investigate into the cause of the fibromyalgia and black out symptoms.

88. Respondent failed to maintain adequate and accurate records relating to the care and treatment of Patient E. On or about September 2, 2014, Respondent documented that Patient E was doing well on her medications. Respondent failed to document any presenting symptoms of anxiety and continued to prescribe multiple controlled substances for anxiety. Respondent failed to document the patient's social history and presenting symptoms sufficiently to ensure on-going

patient safety. Respondent failed to document warning the patient to abstain from alcohol, abstain from illicit drugs or about the possible side effects of prescribed medications. Respondent failed to document warnings to the patient about drug seeking behaviors or medical safety. Respondent failed to document if the patient experienced any functional improvement while taking prescribed medications. Respondent failed to taper prescribed medications after the patient reported that she was doing well.

89. Respondent committed gross negligence in her care and treatment of Patient E, which included, but was not limited to the following:

A. Paragraphs 56 to 88, are hereby incorporated by reference as if fully set forth herein;

B. Respondent prescribed dangerous combinations of controlled substances to a known addict without proper consultation and monitoring;

C. Respondent lacked sufficient knowledge to prescribe opiates to a known addict;

D. Respondent failed to adequately evaluate Patient E after a report of a loss of consciousness while taking multiple dangerous controlled substances; and

E. Respondent failed to maintain adequate and accurate records relating to the care and treatment of Patient E.

Patient F

90. On or about August 4, 2011, Patient F presented to Respondent for treatment for the first time as a nineteen-year-old female desiring to commence weight loss treatment and get a prescription for Adderall. Patient F's history included pre-eclampsia, and migraines. She reported that she had been taking Ultram and over the counter Excedrin migraine, exercising and following a 1200 calorie diet. The review of systems was positive for stress and headaches. The physical examination included check marks in boxes for general, cardiac, lungs, abdomen, extremities, and neuro without any additional comment or explanation. Patient F was 5'5" tall, weighed 215 pounds and her blood pressure was 120/91. Respondent's assessment stated that Patient F had hypertension and migraine. The plan was to treat her with B-complex, and Biotin,

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and return to the clinic in one month. Respondent prescribed Patient F phentermine[17] 37.5 mg #30, one pill daily.

91. On or about September 7, 2011, Patient F presented to Respondent for a follow up visit. Patient F had lost 12 pounds since her prior visit and complained of right shoulder pain resulting from a dislocation about a week prior to the appointment. Patient F reported a reduced range of motion and a history of multiple past dislocations to her right shoulder. The physical examination included a check mark in a box for extremities without any additional comment or explanation. Respondent did not document any evaluation of her range of motion or examine the patient to determine if her shoulder was still dislocated. No x-rays were ordered for her right shoulder. Respondent diagnosed Patient F with right shoulder pain and planned to order a referral to orthopedics. Patient F was directed to return to the clinic in two months. Respondent refilled her prescription for phentermine #30, and prescribed Norco 10/325 #30.

92. On or about September 12, 2011, Patient F contacted Respondent complaining that the generic for Norco that she received on the last visit was not as effective as the brand name. Respondent provided her another prescription for Norco 10/325 #30.

93. On or about November 9, 2011, Patient F returned to Respondent complaining of continued pain in her right shoulder and anxiety. Respondent wrote that her shoulder was "ok" and that she would "see ortho soon." The physical examination included a note that the patient was anxious and a check mark in the box for extremities and a circle around the entry for range of motion. The record does not state what part of the body was positive for a range of motion concern or the extent of the loss of any range of motion. The assessments included right shoulder pain, muscle spasms, and dysthymic. Respondent did not make any recommendations to treat Patient F's anxiety or dysthymia. Respondent prescribed Norco 10/325 #30 and phentermine #30.

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[17] Phentermine is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. Phentermine is a stimulant similar to an amphetamine that acts as an appetite suppressant by affecting the central nervous system. It is used to treat obesity.

94. On or about January 11, 2012, Patient F returned to Respondent's clinic for a follow up on her weight loss treatment. Patient F had not lost any weight since her visit on November 9, 2011. Respondent wrote "implanon → dysmenorrhea 2 x month" along with the word "exercise" in the medical record adjacent to the section for the objective symptoms. Respondent checked the box for extremities again with a circle around the entry for range of motion and no other information to explain what part of the body was positive for a range of motion concern or the extent of the loss of any range of motion. Respondent told the patient to return in two months and prescribed her Norco 10/325 #60, Tramadol[18] 50 mg #60, and phentermine 37.5 #30. Respondent failed to document any information to explain the increase in the prescription of Norco or the addition of a second opiate, Tramadol. Respondent failed to warn Patient F about the dangers of taking multiple concurrent opiates.

95. On or about March 7, 2012, Patient F presented to Respondent's physician assistant asking for help discontinuing her use of phentermine for weight loss. Patient F reported that she was feeling good, eating well, and losing weight. Respondent's physician assistant documented that Patient F requested Norco for painful menstrual cramps and tramadol for headaches. Respondent's physician assistant documented a normal physical examination for everything but weight. The assessment included migraines, menstrual cramps and hair loss. The plan was to prescribe Norco, tramadol, advise the patient to lose weight and return to the office in two months. Respondent's physician assistant prescribed Patient F Norco 10/325 #90 and tramadol #60.

96. On or about April 5, 2012, Patient F returned to the clinic and was seen by Respondent's physician assistant. Respondent's physician assistant prescribed her refills of Norco #90 and phentermine #30.

97. On or about May 9, 2012, Patient F returned to the clinic and was seen by Respondent's physician assistant. Respondent's physician assistant prescribed her refills of

[18] Tramadol is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. Tramadol is a narcotic-like pain reliever and a dangerous drug within the meaning of Business and Professions Code section 4022.

Norco #90.

98. On or about June 15, 2012, Patient F returned to Respondent's clinic and received treatment from her physician assistant. Patient F continued to complain of shoulder pain. The medical record notes that an MRI had been performed and Patient F needed to follow up with her orthopedic surgeon. The physician assistant prescribed Norco 10/325 #30, Soma 350 mg #30, and Lexapro[19]. Respondent's physician assistant failed to document any explanation for the prescription of Soma.

99. On or about July 13, 2012, Patient F returned to Respondent for follow up on her depression symptoms and for refills of her medications. Respondent's only documented assessment of Patient F's mental health symptoms was a single note that stated "Lexapro helps." Respondent did not document any information related to the patient's prescription for Lexapro from another medical provider. Respondent prescribed Patient F Soma #30, Norco #90, and Tramadol #60.

100. From on or about August 15, 2012 through November 15, 2012, Patient F continued to receive monthly refills of her prescriptions for Norco, Soma, and Tramadol.

101. On or about January 22, 2013, Patient F presented to Respondent's physician assistant complaining of continued shoulder pain and a new complaint of difficulty concentrating. Patient F requested a prescription for Adderall because she had previously taken it as a child. Respondent's physician assistant failed to perform an independent evaluation related to her complaint of difficulty concentrating. Respondent's physician assistant prescribed Norco 10/325 #90, Soma 350 #30, Tramadol #60, and Adderall XR 30 mg #30.

102. On or about February 26, 2013, Patient F presented to Respondent's physician assistant for refills of her medications. Respondent's physician assistant prescribed Patient F refills of her Norco, Soma, Tramadol, and Adderall XR.

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[19] Lexapro is an antidepressant in a group of drugs called selective serotonin uptake inhibitors (SSRIs). It affects chemicals in the brain that may be unbalanced in people with depression or anxiety and is a dangerous drug within the meaning of Business and Professions Code section 4022.

103. On or about March 21, 2013, Patient F returned to Respondent for a refill on her medications. Respondent noted that the medications were working well and that the patient wanted to have surgery on her shoulder. Respondent's assessment included right shoulder pain, attention deficit disorder, and headaches. Respondent failed to document any supporting documentation relating to the complaint of continued shoulder pain. Respondent prescribed Patient F Norco #90, Soma #30, Tramadol #60, and Adderall XR #30.

104. From on or about April 15, 2013 through April 15, 2014, Patient F continued to receive monthly prescriptions for Norco #90, Soma #30, Adderall XR #30, and Tramadol #60.

105. On or about May 13, 2014, Patient F returned to Respondent for medication refills and an allergy shot. Respondent noted that Patient F was experiencing an irregular period, but did not provide any additional clarification. Respondent did not perform a pelvic examination or order a pregnancy test. Respondent's assessment stated that the patient had an irregular period and the only plan was to refill medications. Respondent's records for Patient F failed to contain any notes or reports from any orthopedics clinics. Respondent prescribed Patient F Norco #90, Soma #30, and Adderall XR #30

106. From on or about September 7, 2011 through June 26, 2016, Respondent and/or other health professionals at her clinic prescribed Patient F approximately 54 prescriptions for Norco for a total of approximately 5,370 pills. On or about January 11, 2012, Patient F's prescription for Norco was increased from 30 to 60 pills each month. On or about March 7, 2012, Patient F's prescription for Norco was increased from 60 to 90 pills each month. On or about July 25, 2014, Patient F's prescription for Norco was increased from 90 to 120 pills each month.

107. From on or about January 22, 2013 through July 25, 2014, Respondent and/or other health professionals at her clinic prescribed Patient F approximately 17 prescriptions for Adderall XR for a total of approximately 510 pills.

108. From on or about June 15, 2012 through December 17, 2015, Respondent and/or other health professionals at her clinic prescribed Patient F approximately 25 prescriptions for Soma for a total of approximately 1,050 pills. On or about August 23, 2013, Patient F's prescription for Soma was increased from 30 to 45 pills each month. On or about March 12,

2014, Patient F's prescription for Soma was increased from 45 to 60 pills each month.

109. From on or about January 11, 2012 through May 26, 2015, Respondent and/or other health professionals at her clinic prescribed Patient F approximately 19 prescriptions for Tramadol for a total of approximately 1,140 pills.

110. Respondent failed to coordinate care with an orthopedic surgeon or other medical professionals that were treating Patient F for her shoulder pain. Respondent documented that the patient was in the care of an orthopedic surgeon and pending an MRI, but failed to obtain any verification that the information was accurate. Respondent failed to independently verify that Patient F had a surgical lesion present to justify the continued prescribing of multiple controlled substances. Respondent failed to document an adequate shoulder examination. Respondent unnecessarily prescribed controlled substances to Patient F for self-reported shoulder dislocations. Respondent failed to conduct a new shoulder examination after the patient reported improvement. Respondent failed to make any effort to de-escalate the controlled substance therapy when Patient F reported improvement with her shoulder pain. Respondent failed to document Patient F's shoulder function. Respondent failed to de-escalate Patient F's use of controlled substances. After the physician assistant began prescribing Soma, Respondent continued the prescriptions for Soma without documenting an adequate justification for the prescription. Respondent failed to document a sufficient history of attention problems prior to diagnosing Patient F with attention deficit disorder. Respondent initiated amphetamine treatment for attention deficit disorder without obtaining a sufficient patient history of attention problems, utilizing validated diagnostic instruments to support the diagnosis or consulting with mental health professionals. Respondent failed to consider the possibility that polypharmacy might be contributing to Patient F's difficulty concentrating. Respondent failed to document a sufficient clinical justification prior to prescribing an addictive controlled substance to Patient F.

111. Respondent failed to elicit additional information from Patient F about her symptoms after the patient reported experiencing irregular periods. Respondent failed to perform a pelvic exam, pregnancy test, or refer Patient F to a gynecologist for further evaluation after Patient F complained of irregular periods.

112. Respondent committed gross negligence in her care and treatment of Patient F, which included, but was not limited to the following:

A. Paragraphs 90 to 111, are hereby incorporated by reference as if fully set forth herein;

B. Prescribing controlled substances without clinical justification and/or appropriate reevaluation; and

C. Failing to appropriately evaluate a female patient with irregular menstrual cycles.

Patient G

113. On or about March 19, 2013, Patient G presented to Respondent for treatment for the first time as a twenty-seven-year-old male complaining of pain in his hip. Patient G explained that he had previously had hip surgery in October of 2012 and has experienced chronic pain since that time. Patient G completed a new patient questionnaire that denied the use of recreational drugs, but admitted to continued alcohol use. Patient G reported that he was taking Percocet 10-325 two to three times daily and Valium 10 mg daily. Patient G's blood pressure was 167/98. The section of the medical record for the physical exam contains no specific information and includes only a check mark next to the word "EXT." Respondent diagnosed him with chronic pain and made a note in the record that she needed to get medical records. Respondent also noted in the medical record a request for a list of pain management doctors. Respondent told Patient G to return to the clinic in two weeks. Respondent prescribed Patient G Oxycodone 30 mg twice-daily #30 and Valium 10 mg once daily #15.

114. From on or about May 7 through September 18, 2013, Patient G returned to the clinic several times and received refills on his medications from a physician assistant that worked at Respondent's clinic. During these visits, Patient G's blood pressure was routinely documented to be in excess of 140/90.

115. On or about September 18, 2013, Patient G returned to the clinic for refills. Patient G's blood pressure was recorded as 154/93. The medical records contained no outside records from his treating orthopedic surgeon or psychiatrist. The records contain no information

regarding follow up care with Patient G's orthopedic surgeon. The records state that Patient G had a prior MRI that was positive for "bone islands." The medical records contain no other information about the MRI or the date of the MRI findings. Respondent prescribed Patient G Oxycodone 15 mg four times daily #120, and Valium 10 mg ½ to one daily #30.

116. On or about September 28, 2014, Patient G expired. The coroner determined that Patient G's death resulted from a cardiac dysrhythmia and congestive heart failure with left ventricular hypertrophy and chronic passive congestion of the lungs, liver and spleen. The coroner's toxicology report result was only positive for the presence of alcohol; despite the numerous medications he was prescribed by Respondent. The absence of prescription medications in Patient G's toxicology suggests that the prescription medications were being misused or diverted.

117. From on or about March 9, 2013 through September 4, 2014, Respondent and/or other health professionals at her clinic prescribed Patient G approximately 21 prescriptions for Oxycodone for a total of approximately 2,160 pills. On or about April 2, 2013, Patient G's prescription for Oxycodone was decreased from 30 mg to 15 mg; however, the number of pills increased from 30 to 120 per month. On or about October 16, 2013, Patient G's prescription for Oxycodone was increased from 15 mg to 30 mg and the number of pills decreased from 120 to 90 per month. On or about June 20, 2014, Patient G's prescription for Oxycodone was decreased from 30 mg to 15 mg; however, the number of pills increased from 90 to 120 per month.

118. From on or about January 8, 2014 through March 5, 2014, Respondent and/or other health professionals at her clinic prescribed Patient G approximately 3 prescriptions for Dilaudid for a total of approximately 180 pills.

119. From on or about April 2, 2013 through September 4, 2014, Respondent and/or other health professionals at her clinic prescribed Patient G approximately 20 prescriptions for Valium for a total of approximately 630 pills. On or about September 4, 2014, Patient G's prescription for Valium increased from 30 to 60 pills per month.

120. Respondent failed to obtain any medical records from Patient G's orthopedic surgeon or other prior health care providers. Respondent failed to coordinate care with Patient G's other

prior health care providers related to the operative or non-operative treatment plans for his hip. Respondent failed to comment on the lack of any records from other providers during subsequent visits. Respondent failed to refer Patient G to specialists for his pain.

121. Respondent failed to document a clinical justification for continuing Patient G's Valium prescriptions. Respondent failed to document consideration of the risk of continuing to prescribe Valium to Patient G while he was admitting to the continued use of alcohol. Respondent never instructed Patient G to discontinue the use of alcohol while taking controlled substances. Respondent failed to have Patient G sign a pain management contract. Respondent failed to document any prior medications that had been unsuccessfully utilized in the care and treatment of Patient G prior to prescribing him Valium.

122. Patient G's blood pressure was elevated during multiple visits to Respondent as well as other providers seen at Respondent's office. Respondent failed to document any recognition or concern regarding Patient G's persistent elevated blood pressure. Respondent failed to document a relevant history, appropriate physical examination, or order diagnostic testing for Patient G's elevated blood pressure. Respondent failed to order laboratory tests, an EKG, or arrange for follow up care related to Patient G's persistent elevated blood pressure.

123. Respondent committed gross negligence in her care and treatment of Patient G, which included, but was not limited to the following:

A. Paragraphs 113 to 122, are hereby incorporated by reference as if fully set forth herein;

B. Respondent failed to verify Patient G's clinical need for the combination of opiates and benzodiazepines; and

C. Respondent failed to recognize and adequately evaluate Patient G's persistent elevated blood pressure.

Patient H

124. On or about February 10, 2016, Patient H presented to Respondent as a 19-year-old male seeking Adderall for Attention Deficit Disorder. Patient H admitted that he was currently taking Lyrica and Gabapentin and denied smoking, consuming alcohol or using recreational

drugs. Respondent documented in the history of the presenting illness that Patient H had experienced panic attacks for a few years and was having difficulty concentrating in college. Respondent documented a physical exam that included normal vital signs and diagnosed the patient with anxiety, depression, Attention Deficit Disorder and a history of insomnia. Respondent made a note in the record that simply stated "get records." Respondent prescribed Patient H Adderall 10mg ½ tab by mouth twice daily at the first visit. Respondent documented that she provided informed consent and obtained a signed pain management contract from the patient for the use of controlled substances.

125. On or about February 14, 2016, Respondent received a note from Patient H's mother that was included in his medical records. The note explained that Patient H was struggling with addiction and had "filled, used and abused" all of the Adderall prescribed by Respondent within two days of the prescription. The note states that Patient H only visited Respondent's office because he was told by a friend that she would "prescribe anything."

126. Respondent did not review any prior medical records from Patient H's prior treating physicians prior to evaluating him for Attention Deficit Disorder. Respondent did not attempt to obtain medical records from Patient H's prior treating physicians and in fact never obtained any medical records from Patient H's prior treating physicians. Respondent did not perform any objective testing for Attention Deficit Disorder. Respondent did not refer patient H to a specialist for a consultation related to the diagnosis of Attention Deficit Disorder. Respondent elected to prescribe an amphetamine stimulant to Patient H based only on representation from the patient at the initial visit. Respondent failed to document and/or consider the risks of prescribing a stimulant to a patient with self-reported panic disorder and insomnia. Respondent failed to perform a thorough evaluation for Attention Deficit Disorder that would identify possible functional impairment. Respondent inappropriately prescribed amphetamine to Patient H absent a clinical justification or sufficient diagnostic evidence to support the diagnosis and prescription.

127. Respondent failed to adequately document information pertaining to Patient H's psychiatric history. Respondent did not document adequate information relating to Patient H's panic attacks. Respondent failed to adequately document the past history of Patient H's

complaint of anxiety. Respondent failed to document any information relating to prior treatment plans and their efficacy. Respondent diagnosed Patient H with insomnia absent any documentation in the medical record relating to the patients difficulties sleeping.

128. Respondent committed gross negligence in her care and treatment of Patient H, which included, but was not limited to the following:

A. Paragraphs 124 to 127, are hereby incorporated by reference as if fully set forth herein;

B. Respondent failed to adequately evaluate and treat Patient H's Attention Deficit Disorder, which constitutes an extreme departure from the standard of care;

C. Respondent failed to create and maintain adequate and accurate medical records relating to the care and treatment of Patient H, which constitutes an extreme departure from the standard of care.

Patient I

129. On or about January 13, 2016, Patient I presented to Respondent as a 37-year-old female seeking a prescription of Suboxone and to establish Respondent as her primary care physician. Patient I reported that she had been taking Suboxone for ten years and was being drug tested every other weekend. Patient I provided a hand written note from 2012 purporting to be from a psychiatrist recommending that Patient I continue to take Xanax for anxiety while in custody. Patient I also provided a purported 2014 court order that states that the patient should continue taking Xanax, Adderall and participate in random drug testing to continue her visitation rights with her children. Respondent documented a normal physical examination and unremarkable vital signs. Respondent diagnosed Patient I with opioid dependence, Attention Deficit Disorder and anxiety at the first visit. Respondent prescribed her Suboxone, Adderall and Xanax and advised her to return to the office in one month.

130. On or about February 1, 2016, Patient I returned to Respondent for refills of her medications. Respondent documented a normal physical examination and provided her with a prescription for Suboxone. Respondent also provided Patient I with prescriptions for Adderall and alprazolam but dated those prescriptions for February 10, 2016.

131. On or about March 2, 2016, Patient I returned to Respondent for refills of her medications. Respondent documented that Patient I had a tooth abscess and would follow up with a dentist. Respondent provided her with prescriptions for Suboxone, Adderall, alprazolam and amoxicillin.

132. On or about March 28, 2016, Respondent's medical assistant added a note to the medical record stating that Patient I was attempting to obtain Suboxone prescriptions from multiple pharmacies. Patient I had obtained a prescription for Suboxone on March 1, 2018 from one pharmacy and was attempting to obtain an additional prescription for Suboxone at another pharmacy one day later. The Suboxone prescription for March 1, 2018 was written by Respondent, but there is no documentation of this prescription in the medical record.

133. On or about March 30, 2016, Patient I returned to Respondent seeking refills of her prescriptions. Patient I complained of anxiety because she was out on bail, her license plates had been stolen and her boyfriend was in prison. Respondent wrote "got #30 (3/29/16)" in the medical record without further explanation. Respondent did not document any discussion of the violations of the controlled substances contract. Respondent prescribed Patient I alprazolam, Adderall and Suboxone. Shortly after this visit, Respondent obtained information from others indicating that Patient I was illegally selling her controlled substances.

134. On or about April 25, 2016, Respondent provided Patient I new prescriptions for alprazolam, Adderall and Suboxone.

135. Respondent failed to document the reason that the patient was taking Suboxone for 10 years prior to the initial visit. Respondent failed to document and/or consider the risk for polysubstance abuse given the patient's long history of taking Suboxone. Respondent failed to elicit information from Patient I related to red flags for substance abuse. Respondent did document consideration of referring Patient I to specialists in psychiatry, addiction medication or pain management. Respondent failed to adequately monitor Patient I's CURES report for signs of abuse. Respondent relied on the patient's statement that she was required to take Adderall and Xanax pursuant to a two-year-old court order. Respondent did not attempt to verify that the court order was current or legitimate. Respondent failed to document a justification for the prescription

of Suboxone. Respondent failed to notice that the purported court order did not include a requirement that the patient take Suboxone. Respondent failed to document any information regarding Patient I's status related to child custody visitations. Respondent did not obtain any records from other physicians prior to diagnosing the patient with Attention Deficit Hyperactive Disorder at the first visit. Respondent documented that the patient was participating in regular drug testing, but failed to request or review any drug test results. Respondent required Patient I to complete a controlled substances contract that prohibits seeking medications from other providers and attempting to obtain early refills. Respondent was notified that the patient violated the pain contract on multiple occasions and failed to take any corrective action. Respondent did not document any consideration of the multiple violations of the pain management contract and continued prescribing controlled substances to the patient.

136. Respondent committed gross negligence in her care and treatment of Patient I, which included, but was not limited to the following:

A. Paragraphs 129 to 135, are hereby incorporated by reference as if fully set forth herein;

B. Respondent's management of Patient I related to the prescribing of controlled substances constituted an extreme departure from the standard of care.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

137. Respondent has subjected her Physician's and Surgeon's License No. C41745 to disciplinary action under section 2227, as defined by section 2234, subdivision (c), of the Code, in that she committed repeated negligent acts in the care and treatment of Officer A, Officer B, Officer C, Patient D, Patient E, Patient F, Patient G, Patient H and Patient I, as more particularly alleged hereafter:

Officer A

138. Respondent committed repeated negligent acts in her care and treatment of Officer A which included, but was not limited to the following:

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A. Paragraphs 10 to 13, are hereby incorporated by reference as if fully set forth herein;

B. Respondent's prescription of controlled substances to Officer A constitutes a departure from the standard of care.

Officer B

139. Respondent did not adequately address Officer B's high blood pressure. Officer B's blood pressure was greater than 140/90 on two separate visits. Respondent did not repeat the blood pressure at the first visit after the initial elevated result. Respondent did not ask Officer B any questions about his history of high blood pressure. Respondent did not ask for a follow up visit to monitor his high blood pressure. Respondent did not discuss lifestyle modification or other treatment alternatives for his high blood pressure. Respondent did not document any history of high blood pressure or discuss the use of anti-hypertension medications.

140. Respondent committed repeated negligent acts in her care and treatment of Officer B, which included, but was not limited to the following:

A. Paragraphs 15 to 18 and 139, are hereby incorporated by reference as if fully set forth herein;

B. Respondent failed to adequately evaluate Officer B's complaint of shoulder pain, which constitutes a departure from the standard of care;

C. Respondent's prescription of controlled substances to Officer B constitutes a departure from the standard of care; and

D. Respondent failed to adequately evaluate Officer B's elevated blood pressure, which constitutes a departure from the standard of care.

Officer C

141. On or about August 21, 2015, Officer C, an undercover police officer, presented to Respondent's office as a 37-year-old male complaining of headaches. Officer C completed his intake forms and reported that he consumed 1-2 coffees per day and consumed 30-35 alcoholic beverages per week. Officer C told Respondent that he had taken Vicodin and Percocet in the past, but preferred Percocet because he does not feel much effect from taking Norco. Respondent

wrote in Officer C's medical record "hard to focus, hard to get tasks done, OTC med not help has used Norco and Percocets in past, would like to decrease etoh use 5-6 beers/night." Respondent documented a normal abdominal exam in Officer C's medical records. Respondent asked Officer C questions about his headaches, but did not perform a focused neurological examination. Respondent told him that the Norco was "just a pain reliever" and does not treat migraines or muscle tension. Respondent told Officer C that "if you got 30 Percocets that's like getting 45 Norcos." Officer C agreed to try the Norco and return in a month if he needed a refill. Officer C told Respondent that he drinks 5-6 beers a night and has a problem with alcohol. Respondent told him that he "should use pot instead" because it is "so much better for you than alcohol" and is "better for you than Percocet." Respondent then told him that he could get a recommendation for the use of medical marijuana to treat his headaches, sleep issues and to reduce his alcohol intake for the cost of $120. Respondent did not perform a physical examination, but did listen to Officer C's heart during the encounter. Respondent did not make any recommendations to Officer C regarding the need to reduce his alcohol consumption. Respondent diagnosed Officer C with "headaches and etoh use" and prescribed him 30 pills of Percocet to be taken once daily or as needed. Respondent's entire interaction with Officer C lasted approximately eight minutes.

142. On or about September 23, 2015, Officer C returned to Respondent for a refill on medications. Officer C paid $100 cash for a return visit to the front office receptionist. Respondent documented the reason for the visit as "FU Percocet." Respondent noted that Officer C had been doing well on his medications and had been able to reduce his consumption of alcohol. Officer C told Respondent that the Percocet had been working better for him than Vicodin. Respondent explained to Officer C that if he kept taking opiates, he would get to a point where he felt like he needed more of them. Respondent discussed continuing his prescription for Percocet then asked Officer C, "Have you tried cannabis?" Respondent suggested that they could talk about cannabis in the future if the opioids were not working for him. Respondent did not discuss or document any quantitative assessment of Officer C's alcohol use. In the medical record section pertaining to the patient's assessment, Respondent wrote only "headaches" and "etoh use." Respondent's plan for Officer C, simply states, "warned." Respondent prescribed

Officer C 30 additional pills of Percocet 10/325. Respondent told Officer C to return to her office in approximately one month.

143. Respondent failed to document an adequate patient history for Officer C related to his complaint of headaches. Respondent did not document a comprehensive personal and family headache history, perform a focused neurological examination or offer alternative non-opiate treatment options. Respondent did not ask Officer C about possible triggers for his headaches, including but not limited to lack of sleep, hangover from alcohol use, caffeine withdrawal, food or other substances. Respondent did not document what over the counter medications Officer C had previously taken to treat his headaches. Respondent did not consider and/or document consideration of the utilization of non-opiate medications as a part of the treatment plan for Officer C prior to prescribing opiates for his complaint of headaches. Respondent failed to consider the possibility that prescribing opiates could trigger additional headaches. Respondent commenced treatment of Officer C with a high dose of Percocet rather than initiating the patient's prescription at the lowest available effective dosage. Respondent inappropriately prescribed controlled substances to Officer C as a first line of therapy for his complaint of headaches. Respondent prescribed Officer C Percocet despite the possibility for a dangerous interaction between the opiate and his significant alcohol use.

144. Respondent failed to adequately and accurately document Officer C's substance abuse history related to the use of alcohol. Respondent failed to document how long Officer C had been using alcohol and if he had been treated for alcohol abuse in the past. Respondent failed to ask Officer C follow up questions about his alcohol use regarding how much he drank and how frequently. Respondent failed to inform Officer C about the dangers of mixing opiates with alcohol. Respondent failed to document the quantity and frequency of Officer C's alcohol use on his return visit when he reported a decrease in alcohol use. Respondent did not provide Officer C any patient education or treatment options that would address his significant alcohol use.

145. Respondent committed repeated negligent acts in her care and treatment of Officer C, which included, but was not limited to the following:

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A. Paragraphs 141 to 144, are hereby incorporated by reference as if fully set forth herein;

B. Respondent's treatment of Officer C's headaches constitutes a departure from the standard of care.

C. Respondent failed to adequately evaluate and treat Officer C for alcohol use disorder, which constitutes a departure from the standard of care.

Patient D

146. Respondent committed repeated negligent acts in her care and treatment of Patient D, which included, but was not limited to the following:

A. Paragraphs 20 to 54, are hereby incorporated by reference as if fully set forth herein;

B. Respondent inappropriately prescribed controlled substances to Patient D;

C. Respondent lacked knowledge of the appropriate treatment with buprenorphine;

D. Respondent failed to adequately evaluate and treat Patient D's complaint of insomnia; and

E. Respondent failed to adequately evaluate and treat Patient D's complaint of attention deficit disorder.

Patient E

147. Respondent committed repeated negligent acts in her care and treatment of Patient E, which included, but was not limited to the following:

A. Paragraphs 56 to 88, are hereby incorporated by reference as if fully set forth herein;

B. Respondent prescribed dangerous combinations of controlled substances to a known addict without proper consultation and monitoring;

C. Respondent lacked sufficient knowledge to prescribe opiates to a known addict;

D. Respondent failed to adequately evaluate Patient E after a report of a loss of consciousness while taking multiple dangerous controlled substances; and

E. Respondent failed to maintain adequate and accurate records relating to the care

and treatment of Patient E.

Patient F

148. Respondent committed repeated negligent acts in her care and treatment of Patient F, which included, but was not limited to the following:

A. Paragraphs 90 to 111, are hereby incorporated by reference as if fully set forth herein;

B. Prescribing controlled substances without clinical justification and/or appropriate reevaluation; and

C. Failing to appropriately evaluate a female patient with irregular menstrual cycles.

Patient G

149. Respondent committed repeated negligent acts in her care and treatment of Patient G, which included, but was not limited to the following:

A. Paragraphs 113 to 122, are hereby incorporated by reference as if fully set forth herein;

B. Respondent failed to verify the Patient G's clinical need for the combination of opiates and benzodiazepines; and

C. Respondent failed to recognize and adequately evaluate Patient G's persistent elevated blood pressure.

Patient H

150. Respondent committed repeated negligent acts in her care and treatment of Patient H, which included, but was not limited to the following:

A. Paragraphs 124 to 127, are hereby incorporated by reference as if fully set forth herein;

B. Respondent failed to adequately evaluate and treat Patient H's Attention Deficit Disorder;

C. Respondent failed to create and maintain adequate and accurate medical records relating to the care and treatment of Patient H.

Patient I

151. Respondent committed repeated negligent acts in her care and treatment of Patient I, which included, but was not limited to the following:

A. Paragraphs 129 to 135, are hereby incorporated by reference as if fully set forth herein;

B. Respondent failed to adequately manage and prescribe controlled substances to Patient I.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

152. Respondent has subjected her Physician's and Surgeon's License No. C41745 to disciplinary action under section 2227, as defined by section 2266, of the Code, in that she failed to maintain adequate and accurate records in connection with her care and treatment of Officer A, Officer B, Officer C, Patient D, Patient E, Patient F, Patient G, Patient H, and Patient I, as more particularly alleged in paragraphs 10 through 13 (Officer A), 15 through 18 and 139 (Officer B), 141 through 145 (Officer C), 20 through 54 (Patient D), 56 through 88 (Patient E), 90 through 111 (Patient F), 113 through 122 (Patient G), 124 through 127 (Patient H), and 129 through 135 (Patient I), which are hereby incorporated by reference and realleged as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Prescribing Controlled Substances Without an Adequate Prior Examination)

153. Respondent has subjected her Physician's and Surgeon's License No. C41745 to disciplinary action under section 2227, as defined by section 2242, of the Code, in that she prescribed, dispensed, or furnished dangerous drugs as described in Section 4022 without a good faith prior examination and medical indication in the care and treatment of Officer A, Officer B, Officer C, Patient D, Patient E, Patient F, Patient G, Patient H, and Patient I, as more particularly alleged in paragraphs 10 through 13 (Officer A), 15 through 18 and 139 (Officer B), 141 through 145 (Officer C), 20 through 54 (Patient D), 56 through 88 (Patient E), 90 through 111 (Patient F), 113 through 122 (Patient G), 124 through 127 (Patient H), and 129 through 135 (Patient I), which are hereby incorporated by reference and realleged as if fully set forth herein.

FIFTH CAUSE FOR DISCIPLINE

(Incompetence)

154. Respondent has subjected her Physician's and Surgeon's License No. C41745 to disciplinary action under section 2227, as defined by section 2234, subdivision (d), of the Code, in that she lacked competency as described in Section 4022 without a an appropriate prior examination and medical indication in the care and treatment of Officer A, Officer B, Officer C, Patient D, Patient E, Patient F, Patient G, Patient H, and Patient I, as more particularly alleged in paragraphs 10 through 13 (Officer A), 15 through 18 and 139 (Officer B), 141 through 145 (Officer C), 20 through 54 (Patient D), 56 through 88 (Patient E), 90 through 111 (Patient F), 113 through 122 (Patient G), 124 through 127 (Patient H), and 129 through 135 (Patient I), which are hereby incorporated by reference and realleged as if fully set forth herein.

CAUSE TO REVOKE PROBATION

(Failure to Obey All Laws)

155. At all times after the effective date of the Medical Board's Decision and Order in Case No. 08-2009-203165, Condition No. 8 stated:

> "8. OBEY ALL LAWS. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders."

156. Respondent's probation is subject to revocation under Section 2227, subdivision (a)(1), in that she violated the terms of her probation in the Board's May 17, 2013 Decision as set forth in Condition 8, in that she failed to obey all laws, specifically section 2234, subdivision (b), section 2234, subdivision (c), section 2234, subdivision (d), and section 2266 of the Code, as more particularly alleged in paragraphs 9 through 151, above, which are incorporated by reference and realleged as if fully set forth herein.

DISCIPLINARY CONSIDERATIONS

157. To determine the degree of discipline, if any, to be imposed on Respondent Atsuko Eubank Rees, M.D., Complainant alleges that on or about May 17, 2013, in a prior disciplinary action entitled "In the Matter of the Accusation Against Atsuko Eubank Rees, M.D." before the

Medical Board of California, in Board Case No. 08-2009-203165 / OAH Case No. 2012050760, Respondent's license was revoked and the revocation was stayed for a period of (5) years of probation for gross negligence, repeated negligent acts, incompetence, creation of false medical records, employment of persons to procure patients, providing rebates to persons for patient referrals and failing to use her name or an approved fictitious name in advertising for the practice of medicine. That decision is now final and is incorporated by reference as if fully set forth herein.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Respondent Atsuko Eubank Rees, M.D.'s Physician's and Surgeon's Certificate No. C 41745;

2. Revoking the probation that was granted by the Medical Board of California in Case No. 08-2009-203165 and imposing the disciplinary order that was stayed, a revocation of Respondent Atsuko Eubank Rees, M.D.'s Physician's and Surgeon's Certificate No. C 41745;

3. Revoking, suspending or denying approval of Respondent Atsuko Eubank Rees, M.D.'s authority to supervise physician assistants and advanced practice nurses;

4. Ordering Respondent Atsuko Eubank Rees, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

5. Taking such other and further action as deemed necessary and proper.

DATED: May 1, 2018

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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Exhibit A

Case No. 08-2009-203165

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
ATSUKO EUBANK REES, M.D.	)	Case No. 08-2009-203165
Physician's and Surgeon's Certificate No. C 41745	)	
Respondent	)	

DECISION

The attached Stipulated Settlement is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on May 17, 2013.

IT IS SO ORDERED: April 18, 2013.

MEDICAL BOARD OF CALIFORNIA

Reginald Low, M.D., Chair
Panel B

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ROBERT MCKIM BELL
Supervising Deputy Attorney General
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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: ATSUKO REES, M.D., Physician's and Surgeon's Certificate No. C 41745 Respondent.	Case No. 08-2009-203165 OAH No. 2012050760 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. Linda K. Whitney (Complainant) is the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board). She brought this action solely in her official capacity and is represented in this matter by Kamala D. Harris, Attorney General of the State of California, by Peggie Bradford Tarwater, Deputy Attorney General.

2. Respondent Atsuko Rees, M.D. (Respondent) is represented in this proceeding by attorney David L. Fisher, Esq., of Fisher Law Offices, whose address is 1322 Morro Street San Luis Obispo, California 93401.

3. On or about February 19, 1985, the Board issued Physician's and Surgeon's Certificate No. C-41745 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 08-2009-203165 and will expire on September 30, 2014, unless renewed.

JURISDICTION

4. Accusation No. 08-2009-203165 was filed before the Board and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on April 24, 2012. Respondent timely filed her Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 08-2009-203165 is attached as Exhibit A and incorporated by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 08-2009-203165. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. Respondent is fully aware of her legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to be represented by counsel at her own expense; the right to confront and cross-examine the witnesses against her; the right to present evidence and to testify on her own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

8. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

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CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 08-2009-203165, if proven at a hearing, constitute cause for imposing discipline upon her Physician's and Surgeon's Certificate.

10. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the charges in the Accusation, and Respondent hereby gives up her right to contest those charges.

11. Respondent agrees that her Physician's and Surgeon's Certificate is subject to discipline and agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

RESERVATION

12. The admissions made by Respondent herein are only for the purposes of this proceeding, or any other proceedings in which the Medical Board of California or other professional licensing agency is involved, and shall not be admissible in any other criminal or civil proceeding.

CONTINGENCY

13. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or her counsel. By signing the stipulation, Respondent understands and agrees that she may not withdraw her agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

14. The parties understand and agree that facsimile copies of this Stipulated Settlement and Disciplinary Order, including facsimile signatures thereto, shall have the same force and effect as the originals.

15. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. C 41745 issued to Respondent Atsuko Rees, M.D. (Respondent) is revoked. However, the revocation is stayed and Respondent is placed on probation for five (5) years on the following terms and conditions.

1. ACTUAL SUSPENSION. As part of probation, Respondent is suspended from the practice of medicine for 45 days beginning the sixteenth day after the effective date of this decision.

2. PRESCRIBING PRACTICES COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices equivalent to the Prescribing Practices Course at the Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine, approved in advance by the Board or its designee. Respondent shall provide the program with any information and documents that the Program may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one year of enrollment. The prescribing practices course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education requirements for renewal of licensure.

A prescribing practices course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

3. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping equivalent to the Medical Record Keeping Course offered by the Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine, approved in advance by the Board or its designee. Respondent shall provide the program with any information and documents that the Program may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

4. PROFESSIONALISM PROGRAM (ETHICS COURSE). Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations section 1358. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six months after Respondent's initial enrollment, and the longitudinal component of the program not later than the time specified

by the program, but no later than one year after attending the classroom component. The professionalism program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education requirements for renewal of licensure.

A professionalism program taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the program would have been approved by the Board or its designee had the program been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the program or not later than 15 calendar days after the effective date of the Decision, whichever is later.

5. MONITORING - PRACTICE. Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision and Accusation, and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision, Accusation, and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision and Accusation, fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout

probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine, and whether Respondent is practicing medicine safely, billing appropriately or both. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within five calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, Respondent may participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

6. NOTIFICATION. Within seven days of the effective date of this Decision, Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

7. SUPERVISION OF PHYSICIAN ASSISTANTS. During probation, Respondent is prohibited from supervising physician assistants.

8. OBEY ALL LAWS. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

9. QUARTERLY DECLARATIONS. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation. Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

10. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit and all terms and conditions of this Decision.

Address Changes

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021, subdivision (b).

Place of Practice

Respondent shall not engage in the practice of medicine in Respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal

Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty calendar days.

In the event Respondent should leave the State of California to reside or to practice Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

11. INTERVIEW WITH THE BOARD OR ITS DESIGNEE. Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

12. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine in California as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete a clinical training program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; and General Probation Requirements.

13. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

14. VIOLATION OF PROBATION. Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

15. LICENSE SURRENDER. Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject

to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

16. PROBATION MONITORING COSTS. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, David L. Fisher. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 1/2/13

ATSUKO REES, M.D.
Respondent

I have read and fully discussed with Respondent Atsuko Rees, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 1-2-13

David L. Fisher, Esq.
Attorney for Respondent

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ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California of the Department of Consumer Affairs.

Dated: 1/18/13

Respectfully submitted,

KAMALA D. HARRIS
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General

PEGGIE BRADFORD TARWATER
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 08-2009-203165

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Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: ATSUKO EUBANK REES, M.D. 1890 Diablo Drive San Luis Obispo, CA 93405 Physician's and Surgeon's Certificate No. C 41745, Respondent.	Case No. 08-2009-203165 **ACCUSATION**

Complainant alleges:

PARTIES

1. Linda K. Whitney (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs.

2. On or about February 19, 1985, the Medical Board of California issued Physician's and Surgeon's Certificate Number C 41745 to Atsuko Eubank Rees, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on September 30, 2012, unless renewed.

JURISDICTION

3. This Accusation is brought before the Medical Board of California (Board), Department of Consumer Affairs, under the authority of the following laws.

4. Business and Professions Code section 2227[1] provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Division deems proper.

5. Section 2234 of the Code states:

"The Division of Medical Quality[2] shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter [Chapter 5, the Medical Practice Act].

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the

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[1] Unless otherwise noted, all statutory references are to the Business and Professions Code.

[2] Section 2002, as amended and effective January 1, 2008, provides that, unless otherwise expressly provided, the term "board" as used in the State Medical Practice Act (Bus & Prof. Code, §§ 2000, *et seq.*) means the "Medical Board of California," and references to the "Division of Medical Quality" and Division of Licensing" in the Act or any other provision of law shall be deemed to refer to the Board.

applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

". . . ."

6. Section 2261 of the Code states:

"Knowingly making or signing any certificate or other document directly or indirectly related to the practice of medicine or podiatry which falsely represents the existence or nonexistence of a state of facts, constitutes unprofessional conduct."

7. Section 2272 of the Code states: "Any advertising of the practice of medicine in which the licensee fails to use his or her own name or approved fictitious name constitutes unprofessional conduct."

8. Section 2273 of the Code states:

"(a) Except as otherwise allowed by law, the employment of runners, cappers, steerers, or other persons to procure patients constitutes unprofessional conduct.

"(b) A licensee shall have his or her license revoked for a period of 10 years upon a second conviction for violating any of the following provisions or upon being convicted of more than one count of violating any of the following provisions in a single case: Section 650 of this code, Section 750 or 1871.4 of the Insurance Code, or Section 549 or 550 of the Penal Code. After the expiration of this 10-year period, an application for license reinstatement may be made pursuant to Section 2307."

9. Section 650, subdivision (a), of the Code states: "Except as provided in Chapter 2.3 (commencing with Section 1400) of Division 2 of the Health and Safety Code, the offer, delivery, receipt, or acceptance by any person licensed under this division . . . of any rebate, refund, commission, reference, patronage dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement for referring patients, clients, or

customers to any person, irrespective of any membership, proprietary interest, or coownership in or with any person to whom these patients, clients, or customers are referred is unlawful."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

10. Respondent is subject to disciplinary action under section 2234, subdivision (b), in that Respondent was grossly negligent in the care and treatment of patients. The circumstances are as follows:

Factual Allegations re Patient R.S.

11. On or about December 5, 2009, Board Investigator R.C., posing as patient R.S., conducted an undercover visit at Respondent's medical office, a residence in Porterville, California, for the purpose of obtaining a medical marijuana recommendation.[3]

12. R.S. entered the residence and was greeted by "Carol". Carol introduced R.S. to another female who collected one hundred and fifty dollars in cash and asked R.S. to fill out paperwork. R.S. filled out a one-page document with her name, address, and telephone number.

13. Respondent called R.S. into a separate room. Respondent introduced herself and explained that the R.S.'s medical records would be retained in her San Louis Obispo office.

14. R.S. asked Respondent whether her primary care physician would be provided with the records of the visit. Respondent stated that the primary care physician would not be provided the records, and R.S. did not need to tell her primary care physician about the marijuana recommendation because "it doesn't really matter."

15. When R.S. was asked her reasons for wanting the marijuana recommendation, R.S. explained to Respondent that she was stressed with work and with caring for her four children. R.S. said she wanted the marijuana to calm her down and help her relax. Respondent asked R.S. if she had trouble sleeping, and R.S. responded that she had trouble calming down to go to sleep.

[3] Medical marijuana refers to marijuana grown, recommended, or used for medical purposes under Proposition 215, also known as the Compassionate Use Act of 1996. (Health & Saf. Code, § 11362.5.)

R.S. did not complain of difficult sleeping, mention the duration of any insomnia, or mention the duration of her stress complaint. Respondent asked her no questions about the details of the sleep issues.

16. Respondent did not obtain the name of R.S.'s primary care physician, did not coordinate care with R.S.'s primary care physician or any other physician, and did not obtain and/or review prior medical records.

17. The medical record from the visit reflects "a lot of anxiety that affects home and work." It also reflects that R.S. had been suffering from insomnia for a long time and that it made her "cranky and fatigued."

18. Although the medical record reflects a well-developed, well-nourished white female in no acute distress, a grossly normal nervous system, and a heart and extremity examination, Respondent did not physically examine R.S. No vital signs, height or weight measurements were taken. There was no review of systems, no medical history, no notation of drug or other allergies noted, and no questionnaire addressing these areas.

19. Respondent provided a marijuana recommendation to R.S. and advised her to return annually for follow-up appointments.

Allegations of Gross Negligence as to Patient R.S.

20. Respondent was grossly negligent in the care and treatment of R.S. when she failed to perform a physical examination prior to providing a medical marijuana recommendation.

21. Respondent was grossly negligent in the care and treatment of R.S. when she falsified the medical record in support of the marijuana recommendation.

22. Respondent was grossly negligent in the care and treatment of R.S. when she diagnosed anxiety and insomnia without a sufficient medical basis.

23. Respondent was grossly negligent in the care and treatment of R.S. when she failed to conduct a medical record review, failed to coordinate care with R.S.'s primary care provider, or failed to refer R.S. to a consultant for proper evaluation of her complaints.

24. Respondent was grossly negligent in the care and treatment of R.S. when she failed to evaluate R.S. to rule out medical issues that may have been masked or worsened by medical marijuana use.

Factual Allegations re Patient R.M.

25. On or about October 7, 2009, Porterville Police Detective R.M. conducted a visit at Respondent's medical office, a residence in Porterville, California, for the purpose of obtaining a medical marijuana recommendation.

26. Respondent called R.M. into a separate room. Respondent sat behind a desk in the room. There were no medical examination tools present.

27. Respondent asked R.M. why he wanted a recommendation for medical marijuana. R.M. explained that he was stressed at home and suffered anxiety attacks during which he felt his blood pressure was rising. He said he had smoked "pot" with friends, and it seemed to calm him down. Respondent questioned whether the marijuana helped with relaxation and caused him not to be angry or agitated, and R.M. responded that it did. R.M. said he did not want to turn to alcohol because that brings out the "bad" in him. Respondent asked whether R.M. took any medication, and R.M. told her he uses Protonix for acid reflux. She asked him whether he smoked cigarettes and whether he drank alcohol. R.M. stated he smoked cigarettes and rarely drank alcohol. Respondent asked R.M. if the anxiety affected his sleep, and he responded that he occasionally had choking dreams, but that those were rare. No questions about other current or past drug use were asked.

28. The medical record reflects the following: R.M. has complaints of stress affecting home and work and anxiety attacks; R.M. rarely uses alcohol but did smoke; R.M. takes Protonix; he is a well-developed, well-nourished white male in no acute distress; his nervous system is grossly normal; heart examination is normal; abdominal examination is benign; and a lung examination indicates the lungs are clear. No vital signs, height or weight were documented. The assessment is anxiety, and there is no review of systems, no medical history, no notation of drug or other allergies, no name of a primary care provider noted, and no questionnaire reflecting responses in these areas.

29. Respondent handed R.M. a recommendation for medical marijuana. She asked R.M. if he would be growing his own marijuana. R.M. said he did not yet know how to do so and asked if he could use the service provided at the office. Respondent said, "right." She had R.M. sign the bottom of the recommendation, and she explained how much marijuana he could possess and grow. She then added a notation to the recommendation to include "edibles," which would exceed amounts permitted by Senate Bill 420.[4] She informed R.M. that it would be his responsibility to explain the reason for the excessive amount.

30. Respondent gave R.M. a form explaining the health risks of smoking marijuana. She told R.M. that she thought marijuana plants contained tar, and he could ask Carol about a vaporizer that would burn "cleaner" and also about "edibles." She provided another form advising R.M. to see his doctor for any other health issues, and told R.M. he did not need to notify his doctor about the medical marijuana.

31. In spite of the notations in the medical record, Respondent did not examine R.M. prior to recommending medical marijuana.

32. Respondent began writing a recommendation for marijuana in under three minutes from the start of the visit. R.M.'s entire visit with Respondent lasted less than six minutes.

Allegations of Gross Negligence as to Patient R.M.

33. Respondent was grossly negligent in the care and treatment of R.M. when she failed to perform a physical examination prior to providing a medical marijuana recommendation.

34. Respondent was grossly negligent in the care and treatment of R.M. when she falsified the medical record supporting the marijuana recommendation.

35. Respondent was grossly negligent in the care and treatment of R.M. when she diagnosed anxiety without a sufficient medical basis.

36. Respondent was grossly negligent in the care and treatment of R.M. when she failed to conduct a medical record review, failed to coordinate care with R.M.'s primary care provider, or failed to refer R.M. to a consultant for proper evaluation of her complaints.

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[4] These limits are set forth in Health & Safety Code section 11362.77.

37. Respondent was grossly negligent in the care and treatment of R.M. when she failed to evaluate R.M. to rule out medical issues that may have been masked or worsened by medical marijuana use.

Factual Allegations re Patient A.D.

38. On or about October 8, 2010, San Luis Obispo Police Officer A.D, posing as patient A.D., conducted an undercover visit at Respondent's medical office, Rees Family Medical, in San Luis Obispo, California, for the purpose of obtaining a medical marijuana recommendation.

39. A.D. was called into a room to see Physician Assistant M.E. The progress note from the visit indicates pulse and blood pressure numbers and a notation that A.D. is taking no medications. It indicates that A.D. has back pain in the lower thoracic and upper lumbar area from a bicycle accident and that the pain bothers her at the end of the day. The note reflects that A.D. is a student. Her pain is aggravated by sitting, and using medical marijuana allows her to relax, sleep better, and have a more productive day. According to the physical examination notes, the heart has a normal sinus rhythm without murmur or gallop, and lungs are clear. A.D. is setting and walking normally. The assessment is back pain, and there is a remark that A.D. understands the protocol and will comply with the responsibility and follow up as needed. The note is signed by M.E. and initialed by Respondent. There are no notations relating to what A.D. had done in the past to reduce pain, other than the use of marijuana, and there are no suggestions of what she might try, other than marijuana, for her problem. There is no drug allergy history, review of systems, or medical history in the medical record.

40. Neither Respondent nor M.E. obtained information relating to A.D.'s medical history from A.D.'s primary care physician, neither coordinated care with A.D.'s primary care physician or any other physician, and neither reviewed or obtained prior medical records.

Allegations of Gross Negligence as to Patient A.D.

41. Respondent was grossly negligent in the care and treatment of A.D. when she recommended medical marijuana without conducting a medical record review, coordinating care with A.D.'s primary care provider, or referring A.D. to a consultant for proper evaluation of her complaints.

42. Respondent was grossly negligent in the care and treatment of A.D. when she recommended medical marijuana without ruling out medical issues that may have been masked or worsened by medical marijuana use.

43. Respondent was grossly negligent in the care and treatment of A.D. when she delegated to M.E. the responsibility of conducting A.D.'s physical examination, evaluation, and granting of the medical marijuana recommendation without providing direct supervision.

Factual Allegations re Patient R.R.

44. In 2008, patient R.R., a physician, was placed on probation for a period of five years with terms and conditions that included abstention from use of controlled substances and requiring R.R. to notify the Board upon receiving any lawful prescription medications.

45. On or about May 14, 2010, R.R. presented at Respondent's medical office, Rees Family Medical, in San Luis Obispo, California, for the purpose of obtaining a medical marijuana recommendation.

46. At the time of his visit, R.R. provided a prescription pad sheet from G.B., M.D., dated May 5, 2010, on which G.B. indicated that R.R. had a diagnosis of lumbo-sacral disc disease and noted "pt appropriate Disease for Medical Marijuana." R.R. also provided a copy of MRI reports, dated October 16, 2001 and June 20, 2001, which revealed disc protrusions, foraminal stenosis facet disease and subluxation, and severe central stenosis at L4-5. R.R. included a copy of a previous medical marijuana recommendation, which had expired on January 29, 2009.

47. R.R. was seen by Physician Assistant M.E. The progress note from the visit indicates R.R.'s age of 58 years and indicates that he was sent by G.B. for degenerative disc disease unresponsive to surgery. The office visit notes the use of Coumadin, Vytoran, Flomax, and Imiprimine as current medications. The remainder of the note states that the pain involves the entire back, it is worse at the lumbo-sacral area, and the pain is felt with flexion and extension. It notes there is a positive straight leg raising test on both sides, that the neurologic examination was "intact," and that the patient provided records. The assessment is "chronic pain syndrome – legs and back."

48. G.B.'s note does not contain a list of current medications used by R.R. There is no notation in the patient record of any pain or sleep medication used by R.R. currently or in the past. There are no forms or documentation that include past medical, surgical, social, or drug dependency or abuse issues.

49. No vital signs were obtained or documented in the chart, and no physical examination was performed on R.R. during his visit at Rees Family Medical.

50. Respondent signed and reviewed R.R.'s chart, but not until after R.R. received the recommendation for medical marijuana.

Allegations of Gross Negligence as to Patient R.R.

51. Respondent was grossly negligent in the care and treatment of R.R. when she recommended medical marijuana without conducting a general physical examination.

52. Respondent was grossly negligent in the care and treatment of R.R. when she recommended medical marijuana without conducting a sufficient evaluation to rule out medical issues that may have been masked or worsened by medical marijuana use.

53. Respondent was grossly negligent in the care and treatment of R.R. when she delegated the entire process of making the medical marijuana recommendation to a physician assistant without directly supervising the physician assistant or reviewing the medical record prior to issuance of the recommendation.

54. Respondent was grossly negligent in the care and treatment of R.R. when she failed to discuss with R.R. the potential risks of the use of marijuana in conjunction with Coumadin.

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SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

55. Respondent is subject to disciplinary action under section 2234, subdivision (c), in that Respondent committed repeated acts of negligence in the care, treatment and management of patients. The circumstances are as follows:

Factual Allegations re Patient R.S.

56. The facts and circumstances alleged in paragraphs 11 through 19 are incorporated here as if fully set forth.

Allegations of Negligence re Patient R.S.

57. Respondent was negligent in the care and treatment of R.S. when she failed to perform a physical examination prior to providing a medical marijuana recommendation.

58. Respondent was negligent in the care and treatment of R.S. when she falsified the medical record in support of the marijuana recommendation.

59. Respondent was negligent in the care and treatment of R.S. when she diagnosed anxiety and insomnia without a sufficient medical basis.

60. Respondent was negligent in the care and treatment of R.S. when she failed to conduct a medical record review, failed to coordinate care with R.S.'s primary care provider, or failed to refer R.S. to a consultant for proper evaluation of her complaints.

61. Respondent was negligent in the care and treatment of R.S. when she failed to evaluate R.S. to rule out medical issues that may have been masked or worsened by medical marijuana use.

Factual Allegations re Patient R.M.

62. The facts and circumstances alleged in paragraphs 25 through 32 are incorporated here as if fully set forth.

Allegations of Negligence re Patient R.M.

63. Respondent was negligent in the care and treatment of R.M. when she failed to perform a physical examination prior to providing a medical marijuana recommendation.

64. Respondent was negligent in the care and treatment of R.M. when she falsified the medical record supporting the marijuana recommendation.

65. Respondent was negligent in the care and treatment of R.M. when she diagnosed anxiety without a sufficient medical basis.

66. Respondent was negligent in the care and treatment of R.M. when she failed to conduct a medical record review, failed to coordinate care with R.M.'s primary care provider, or failed to refer R.M. to a consultant for proper evaluation of her complaints.

67. Respondent was negligent in the care and treatment of R.M. when she failed to evaluate R.M. to rule out medical issues that may have been masked or worsened by medical marijuana use.

Factual Allegations re Patient A.D.

68. The facts and circumstances alleged in paragraphs 38 through 40 are incorporated here as if fully set forth.

Allegations of Negligence re Patient A.D.

69. Respondent was negligent in the care and treatment of A.D. when she recommended medical marijuana without a medical record review, coordinating care with A.D.'s primary care provider, or referring A.D. to a consultant for proper evaluation of her complaints.

70. Respondent was negligent in the care and treatment of A.D. when she recommended medical marijuana without ruling out medical issues that may have been masked or worsened by medical marijuana use.

71. Respondent was negligent in the care and treatment of A.D. when she delegated to M.E. the responsibility of conducting A.D.'s physical examination, evaluation, and granting of the medical marijuana recommendation without providing direct supervision.

Factual Allegations re Patient R.R.

72. The facts and circumstances alleged in paragraphs 44 through 50 are incorporated here as if fully set forth.

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Allegations of Negligence re Patient R.R.

73. Respondent was negligent in the care and treatment of R.R. when she recommended medical marijuana without conducting a general physical examination.

74. Respondent was negligent in the care and treatment of R.R. when she recommended medical marijuana without conducting a sufficient evaluation to rule out medical issues that may have been masked or worsened by medical marijuana use.

75. Respondent was negligent in the care and treatment of R.R. when she delegated the entire process of making the medical marijuana recommendation to a physician assistant without directly supervising the physician assistant or reviewing the medical record prior to issuance of the recommendation.

76. Respondent was negligent in the care and treatment of R.R. when she failed to discuss with R.R. the potential risks of the use of marijuana in conjunction with Coumadin.

THIRD CAUSE FOR DISCIPLINE

(Incompetence)

77. Respondent is subject to disciplinary action under section 2234, subdivision (d), in that Respondent exhibited incompetence in the care and treatment of patients. The circumstances are as follows.

Factual Allegations re Patient R.S.

78. During her December 5, 2009 appointment with Respondent, R.S. inquired whether her primary care physician would be given the records of her visit with Respondent. Respondent stated that he would not receive the documents, and that R.S. did not need to tell her primary physician that she obtained a medical marijuana recommendation unless she wanted to tell him because, "it doesn't really matter."

Allegation of Incompetence as to Patient R.S.

79. Respondent displayed a lack of knowledge and experience when she failed to encourage R.S. to notify her primary care physician regarding her use of medical marijuana.

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Factual Allegations re Patient R.M.

80. During his October 7, 2009 appointment with Respondent, R.M. inquired whether he should notify his physician about the medical marijuana recommendation, and Respondent answered, "no."

Allegation of Incompetence as to Patient R.M.

81. Respondent displayed a lack of knowledge and experience when she advised R.M that he did not need to notify his primary care physician regarding his recommendation for the use of medical marijuana.

FOURTH CAUSE OF ACTION

(Creation of a False Medical Record)

82. Respondent is subject to disciplinary action under section 2261 in that Respondent created false medical records. The circumstances are as follows:

83. Respondent created a false medical record as to R.S. when Respondent noted a physical examination of R.S. without having actually completed a physical examination.

84. Respondent created a false medical record as to R.M. when Respondent noted a physical examination of R.M. without having actually completed a physical examination.

FIFTH CAUSE FOR DISCIPLINE

(Employment of Person to Procure Patients)

85. Respondent is subject to disciplinary action under section 2273, subdivision (a), in that Respondent employed a person to procure patients. The circumstances are as follows:

86. From approximately November 2009, through the year 2010, Respondent employed C.A. to place advertisements relating to medical marijuana recommendations and to send out cards to notify people of the dates and locations of clinics run for the purpose of recommending medical marijuana.

87. Respondent paid C.A. for the costs of advertising and for the patient referrals. Respondent paid C.A. approximately fifteen to twenty-five dollars per patient.

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SIXTH CAUSE FOR DISCIPLINE

(Rebates for Patient Referrals)

88. Respondent is subject to disciplinary action under section 650 in that Respondent offered rebates for patient referrals. The circumstances are as follows:

89. The facts and circumstances alleged in paragraphs 85 and 86 are incorporated here as if fully set forth.

SEVENTH CAUSE FOR DISCIPLINE

(Failure to use Name in Advertising)

90. Respondent is subject to disciplinary action under section 2272 in that Respondent advertised the practice of medicine without using her own name or an approved fictitious name. The circumstances are as follows:

91. Respondent advertised medical marijuana services in the Porterville, California "Save-A-Buck" newspaper, dated November 5, 2009. The advertisement does not contain either Respondent's name or a fictitious name permitted for Respondent's use.

92. Respondent advertised medical marijuana services in the San Luis Obispo "New Times" newspaper, Volume 25, Number 33 for March 17 through 24, 2011. The advertisement does not contain either Respondent's name or a fictitious name permitted for Respondent's use.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number C 41745, issued to Atsuko Rees, M.D.

2. Revoking, suspending or denying approval of her authority to supervise physician assistants, pursuant to section 3527 of the Code;

3. If placed on probation, ordering her to pay the Medical Board of California the costs of probation monitoring;

4. Taking such other and further action as deemed necessary and proper.

DATED: April 24, 2012

LINDA K. WHITNEY
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California,
Complainant

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